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REPORT OF THE COURT OF INQUIRY

Executive Summary

What Happened

1. (U) On 12-13 October 2017, D Squadron of 1 NZSAS Regiment were conducting a regular Maritime Counter Terrorism (MCT) exercise with the Motor Vessel (MV) Olivia Maersk. During the conduct of this activity, an accident occurred that resulted in the death of M995290 SGT W.R. Taylor, RNZIR.
2. (U) The accident happened offshore to the east of the Coromandel Peninsular at 0611. Weather conditions were moderate with good visibility, and the accident occurred at or around civil twilight with light levels sufficient for the operators to be able to see what they were doing clearly.
3. (R) SGT Taylor was the final person of a ^{s. 6(a)} assault group from his Rigid Hulled Inflatable Boat (RHIB) to climb a ^{s. 6(a)} ladder that had been attached to the MV Olivia Maersk by the group (a process known as tagging). While the final two climbers were on the ladder, the guardrail onto which the ladder was attached deformed in the centre without fully snapping. SGT Taylor reached approximately halfway up the ^{s. 6(a)} climb, when he encountered difficulty, and, after a short 1-2 minute period, he fell from the ladder.
4. (U) Having fallen from the ladder, SGT Taylor struck the RHIB below him and was knocked unconscious. He then entered the water without further contact with the RHIB or the ship and was swept astern through the wake. The life jacket he was wearing was not an auto-inflation model, and, during the 1 to 2 minutes in the water before he was recovered, he inhaled sufficient seawater to cause drowning.
5. (U) Resuscitation efforts which commenced approximately 7 minutes after the fall and continued during the emergency evacuation by RHIB to shore were unsuccessful. SGT Taylor was landed to the beach at Port Jackson at approximately 0710. Following further resuscitation efforts ashore both by members of the assault team and an attending Westpac helicopter crew, SGT Taylor was pronounced dead at 0745 13 October 2017.
6. (U) A timeline of events is at Annex A.

What the Court Found

7. (U) The Court made the following key findings:
 - a. There were two contributing factors to the death of SGT Taylor.
 - i. Firstly, the difficulty associated with climbing using a ^{s. 6(a)} ladder which ultimately occasioned the fall;

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- ii. Secondly, the use, due to operational reasons, of a manually activated life jacket which rendered him vulnerable to drowning when entering the water unconscious.
- b. All involved personnel were on duty at the time of the accident and were appropriately qualified.
- c. There were varying degrees of experience amongst the team with SGT Taylor amongst the most experienced.
- d. The level of difficulty of the climb was challenging and towards the upper limit but within what would normally be expected of Special Forces Operators and should normally have been within SGT Taylor's ability.
- e. The most likely reason for the fall was fatigue encountered during the climb.
8. (R) The level of training conducted by D Squadron personnel was found to be sufficiently robust to conduct tagging operations underway.
9. (U) The medical evidence provided in the autopsy and by the pathologist is consistent with salt water drowning.
10. (U) All medical treatment given to SGT Taylor was of a high standard and compliant with Defence Medical Treatment Protocols; no further treatment could reasonably have been provided under the circumstances.
11. (U) The actions of the MV Olivia Maersk played no part in the cause or subsequent effects of the accident.
12. (U) Planners carried out appropriate risk management steps for the activity in accordance with established procedures, but improvements can be made in the area of monitoring individual levels of currency for underway tagging.
13. (U) The briefing process was in accordance with standing orders, and the briefing of detailed contingency plans contributed to the rapid and effective response by personnel when the accident occurred.
14. (U) SGT Taylor's equipment was configured in a standard fashion that was well-established and trusted by the operators; all the assault equipment he was using had been introduced into service.
15. (U) Manufacturer's specifications for the ladder and ancillary equipment used in the operation indicate that it is fit for purpose, however, some documentation is incomplete and the current inspection regime does not certify ladders to the appropriate specification.
16. (U) All safety equipment used by personnel during this activity functioned as expected. The Special Forces Lifejacket remains fit for purpose in the Maritime Counter Terrorism role; however, a new system currently under trial may provide improved performance.
17. (U) The provision of an automatically activated Personal Flotation Device (PFD) may have altered the outcome of this accident.

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18. (U) The Court made a number of recommendations key amongst them covering:
- a. Recertification of ~~s. 6(a)~~ ladders and ancillary equipment to account for the actual loads to which they are likely to be subjected ~~s. 6(a)~~
 - b. Investigation into the viability for the provision of an automatically activated PFD.
 - c. Completion of the trial currently underway for a potential alternative to the SFLJ.
 - d. Provision of guidance on expected currency for personnel conducting underway tagging operations and a process to monitor such currency.
 - e. Formalising the use of systems for supporting a climber's weight as a potential treatment to the hazard of fatigue leading to falls.

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General

19. (U) The inquiry was carried out over the period 25 October 2017 to 15 May 2018. Evidence from 51 witnesses was considered.
20. (U) For security reasons, active members of D Squadron are referred to in this report by call signs. Exhibit V is a list of personnel against their call signs.

Overview of the Accident

21. (U) On 12-13 October 2017, D Squadron of 1 NZSAS Regiment were conducting ~~s. 6(a)~~ a Maritime Counter Terrorism (MCT) exercise with the Motor Vessel (MV) Olivia Maersk (Fig 1) as part of regular activity to maintain the required Operational Level of Capability (OLOC)¹ for counter terrorism outputs.² During the conduct of this activity, an accident occurred that resulted in the death of M995290 SGT W.R. Taylor, RNZIR.
22. (U) The accident happened offshore to the east of the Coromandel Peninsular at 0611 on 13 October 2017³ in position 175 35 24 East 36 26 10 South.
23. (U) Weather conditions were wind force 3-4 reducing, with a 1-2m swell and good visibility in partly cloudy conditions. The accident occurred at or around civil twilight with light levels sufficient to allow witnesses to clearly see the events unfolding and for the operators to be able to clearly see what they were doing.
24. (R) SGT Taylor was the final person of a ~~s. 6(a)~~ assault group from his Rigid Hull Inflatable Boat (RHIB) to climb a ~~s. 6(a)~~ adder that had been attached to the MV Olivia Maersk by the group (a process known as tagging).⁴ Approximately halfway up the ~~s. 6(a)~~ climb, he encountered difficulty, and, after a short 1-2 minute period,⁵ he fell from the ladder.⁶
25. (U) There is no evidence to suggest that a material failure of any of the equipment being used in the operation contributed to the fall.⁷
26. (U) Having fallen from the ladder, SGT Taylor struck the RHIB below him and was knocked unconscious.⁸ He then entered the water without further contact with the RHIB or the ship⁹ and was swept astern through the

¹ The declared standard to which forces fit for operations are measured.

² Witness 1, 30 November 2017, Q12; Witness 46, 25 January 2018, Q4-7.

³ Witness 12, 2 November 2017, Q50; Exhibit AP (Position marked A); Exhibit B p 44.

⁴ Witness 35, 23 November 2017, Q3.

⁵ See para 64-68.

⁶ See para 69-70.

⁷ See para 68.

⁸ Witness 43, 14 December 2017, Q7; Exhibit CR p 4 para 2.

⁹ See para 72; Witness 9, 1 November 2017, Q88; Witness 6, 1 November 2017, Q73-75.

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wake.¹⁰ The life jacket he was wearing was not an auto-inflation model,¹¹ and, during the 1 to 2 minutes in the water before he was recovered, he inhaled sufficient seawater to cause drowning.¹²

27. (U) Resuscitation efforts which commenced approximately 7 minutes after the fall¹³ and continued during the emergency evacuation by RHIB to shore were unsuccessful. SGT Taylor was landed to the beach at Port Jackson at approximately 0710.¹⁴ Following further resuscitation efforts ashore both by members of the assault team and an attending Westpac helicopter crew, SGT Taylor was pronounced dead at 0745 13 October 2017.¹⁵
28. (U) A timeline of events is at Annex A.
29. (U) In respect of the above incident and the terms of reference set out by the assembling authority, the Court records its findings below.



(U) Fig 1 MV Olivia Maersk¹⁶

Duty Status of Personnel

30. (U) All involved personnel were on duty at the time of the incident.¹⁷

¹⁰ See para 72; Witness 29, 22 November 2017, Q22-26.

¹¹ Witness 1, 30 October 2017, Q67.

¹² Witness 43, Q5-6; Exhibit CR p 3 para 1, p 5 para 8.

¹³ See para 85-87.

¹⁴ Witness 1, 30 October 2017, Q77.

¹⁵ Ibid; Exhibit BF.

¹⁶ Exhibit Q, p 3.

¹⁷ Witness 1, 30 October 2017, Q4; Witness 5, 31 October 2017, Q3; Witness 2, 30 October 2017, Q3; Witness 6, 1 November 2017, Q6.

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Safety & Supervising Staff and Qualifications

31. (U) The following personnel were employed in safety roles during the incident:

- s. 6(a) - safety supervisor;¹⁸
- Amphibious safety non-commissioned officer (NCO);¹⁹
- ship safety officer s. 6(a)
- ship safety s. 6(a)
- ship safety Bridge;²²
- medical safety;²³
- safety comms;²⁴
- coxswain of safety RHIB;²⁵ and navigator of safety RHIB.²⁶

32. (U) These personnel were all properly qualified to hold these roles.²⁷ The role of amphibious safety would normally be undertaken by the RHIB detachment sergeant; however, this position was filled at the time by s. 6(a) who was the acting I/C of the detachment. As he was not qualified to hold the safety role associated with his acting position, s. 6(a) took on that role for the exercise.²⁸ Personnel conducting safety roles are exposed to hazard identification training during routine unit training periods.²⁹

33. (U) s. 6(a) the supervisor for s. 6(a) was not under training at the time of the incident.³⁰

Time and Exact Location of Accident

34. (U) The Court finds that the accident happened offshore to the east of the Coromandel Peninsula at 0611 on 13 October in position 175 35 24 East 36 26 10 South.

35. (U) The time and location were established to a high level of accuracy from Global Positioning System (GPS) data taken from the navigation

¹⁸ Witness 1, 30 October 2017, Q5-8; Witness 2, 30 October 2017, Q5-6; Witness 3, 31 October 2017, Q6-7.

¹⁹ Witness 1, 30 October 2017, Q5-8; Witness 2, 30 October 2017, Q5-6; Witness 3, 31 October 2017, Q6-7.

²⁰ Witness 1, 30 October 2017, Q5-8; Witness 2, 30 October 2017, Q5-6; Witness 3, 31 October 2017, Q6-7.

²¹ Witness 3, 31 October 2017, Q6-7; Witness 29, 22 November 2017, Q2.

²² Witness 31, 22 November 2017, Q2.

²³ Witness 20, 21 November 2017, Q3.

²⁴ Witness 17, 3 November 2017, Q6-8.

²⁵ Witness 12, 2 November 2017, Q5.

²⁶ Witness 19, 3 November 2017, Q6.

s. 6(a)

²⁸ Witness 1, 30 October 2017, Q35.

²⁹ Witness 1 4 May 2018 Q16

³⁰ Witness 1, 30 November 2017, Q6-8; Witness 2, 30 November 2017, Q5-8.

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systems of the RHIBs undertaking the exercise³¹ combined with evidence from s. 6(a) the coxswain of the safety boat, who was approximately 50-100m from the accident.³²

36. (U) The timing of the accident was corroborated by a number of other witnesses, in particular Witness 1³³ and Witness 3.³⁴

Light, Sea and Wind Conditions

37. (U) The Court finds the following:

- a. Wind Conditions: force 3-4 reducing. Moderate breeze around 15-20 knots from the west.
- b. Sea Conditions: 1-2m swell from the west.
- c. Light Conditions: good visibility in partly cloudy conditions. The accident occurred at or around civil twilight with light levels sufficient to allow witnesses to clearly see the events unfolding and for the operators to be able to clearly see what they were doing.

38. (U) Weather conditions at the time were variously reported by witnesses with a spread of interpretations depending on the witnesses' experience. In determining the definitive conditions, the Court gave greater weight to those with experience at sea and in reporting weather conditions, such as:

- a. s. 6(a) the Troop Commander, s. 6(a) reported the conditions to be easterly 15-20 knots gusting 25 with a 1-2 m swell.³⁵
- b. Witness 45, s. 6(a) who observed the conditions shortly after the accident at 0630 reported westerly force 3 or 4 and reducing from an overnight westerly 4 or 5.³⁶ The MV Olivia Maersk's logbook indicates force 4 at 0300, 4 at 0400 and 5 at 0700, there was no record of the wind strength for 0500 or 0600.³⁷ The Court determines that the increase in wind speed by 0700 is most likely due to the ship's transit through the less sheltered Colville Channel rather than an indication that the weather was deteriorating.
- c. s. 6(a) the acting RHIB detachment commander, had planned from a weather forecast of swell westerly 2-2.5m, wind south westerly 20 kts gusting 30

³¹ Witness 10, 2 November 2017, Q13-14; Witness 24, 30 November 2017, Q2; Exhibits AI p 7 and CI.

³² Witness 12, Q47-50; Exhibit AP.

³³ Witness 1, 30 October 2017, Q25; Exhibit B p 45.

³⁴ Witness 3, Q108.

³⁵ Witness 5, 31 October 2017, Q33.

³⁶ Witness 45, 21 December 2017, Q14-16.

³⁷ Exhibit CZ.

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- kts, sea state slight to moderate, in fair visibility with odd showers.³⁸ He recalled that conditions on the night were slightly better than forecasted.³⁹
- d. ~~s. 6(a)~~ indicated a westerly wind and sea direction in his diagram showing the approach of the RHIBs to the target vessel.⁴⁰ ~~s. 6(a)~~ and Ship Safety Officer for the exercise, described visibility as good with a slight chop on the sea.⁴¹
- e. The Court considers that the discrepancy in wind direction given by ~~s. 6(a)~~ is a simple error in reporting the direction at the time of the interview.
39. (U) Sun rise and twilight data for the location and time of the accident indicate that civil twilight occurred at 0611 with sunrise at 0637.⁴² Witnesses' recollection of light levels varied, but, for the final approach to the target vessel, ~~s. 6(a)~~ provided a clear recollection which is consistent with a civil twilight time of 0611: colours could be discerned and identification of safety staff on the target vessel was easy from their high visibility vests.⁴³ ~~s. 6(a)~~ recalled that night vision goggles were not required and that it was easy to see what he was doing and that climbers were visible from the RHIB when at the top of the ladder.⁴⁴

Detailed Description of the Accident

40. (U) The plan for the exercise called for ~~s. 6(a)~~ RHIBs to transport ~~s. 6(a)~~ assault teams and a command and safety element to intercept the MV Olivia Maersk and conduct a waterborne assault.⁴⁵ Already embarked in the vessel prior to her sailing from Tauranga were additional safety personnel including ~~s. 6(a)~~ a sergeant acting as the Ship Safety Officer,⁴⁶ ~~s. 6(a)~~

³⁸ Witness 11, 2 November 2017, Q8; Exhibit AJ, p 5.

³⁹ Witness 11, 2 November 2017, Q17.

⁴⁰ Exhibit I.

⁴¹ Witness 3, 31 October 2017, Q30.

⁴² Exhibit DM.

⁴³ Witness 2, 30 October 2017, Q44.

⁴⁴ Witness 6, 1 November 2017, Q37-38.

⁴⁵ Witness 5, 31 October 2017, Q42-44.

⁴⁶ Witness 1, 30 October 2017, Q5; Witness 5, 31 October 2017, Q4-5.

⁴⁷ Witness 3, 31 October 2017, Q14-15.

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s. 6(a)

- (U) Fig 2 Disposition of Personnel at start of Assault.⁴⁸ Not to Scale
41. (U) RHIB ³ contained an assault team including s. 6(a) who was in tactical command.⁵⁰
42. (U) RHIB ³¹ contained s. 6(a) assault team including SGT Taylor, who was D Squadron's s. 6(a) and second in command at the tactical level.⁵²
43. (U) The s. 6(a) boat, referred to as Safety RHIB,⁵³ contained:
- a. s. 6(a) D Squadron's s. 6(a) in overall command;⁵⁴
 - b. s. 6(a) acting as RHIB Safety Officer;⁵⁵
 - c. s. 6(a) a medic; and
 - d. s. 6(a) a signaller.
44. s. 6(a)
45. s. 6(a)

The Safety RHIB would remain s. 6(a) in a position to maintain visual contact as far as possible with s. 6(a) assault teams.⁵⁶

46. (R) At approximately 0550, having intercepted the target vessel, the RHIBs were s. 6(a) ⁵⁷ s. 6(a) had

s. 6(a)

⁵² Ibid.
s. 6(a)

⁵⁴ Ibid.

⁵⁵ Witness 1, 30 October 2017, Q5; Witness 5, 31 October 2017, Q4-5.

⁵⁶ Witness 2, 30 October 2017, Q31-34; Exhibit I.

⁵⁷ Witness 5, 31 October 2017, Q66; Exhibit A1, p 4.

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contacted MV Olivia Maersk via radio to ensure that the ship was ready to begin the exercise,⁵⁸ and this had been confirmed,⁵⁹ the ~~s. 6(a)~~ then gave the order to commence the assault.⁶⁰ The MV Olivia Maersk was on a course of ~~s. 6(a)~~

⁵²

47 ~~s. 6(a)~~

48 ~~s. 6(a)~~

⁵⁷ The Safety RHIB now moved to a position in line with RHIB about 50m off.⁶⁸

~~s. 6(a)~~

~~s. 6(a)~~

⁵⁸ Witness 2, 30 October 2017, Q42.

⁵⁹ Witness 31, 22 November 2017, Q7.

⁶⁰ Witness 5, 31 October 2017, Q66.

⁶¹ Witness 45, 21 December 2017, Q7; Exhibit CZ.

⁶² Witness 31, 22 November 2017, Q12.

⁶³ Further detail of this problem is expanded at para 187.

⁶⁴ Witness 18, 3 November 2017, Q34; Witness 11, 02 November 2017, Q49.

⁶⁵ Witness 5, 31 October 2017, Q68.

⁶⁶ Witness 11, 2 November 2017, Q50.

⁶⁷ Witness 11, 2 November 2017, Q28 and 50-51; Witness 5, 31 October 2017, Q68.

⁶⁸ Witness 2, 30 October 2017, Q35-42.

⁶⁹ Exhibit V. NB appears in RHIB in Exhibit V as he transferred to this boat after the accident.

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49. (R) RHIB made its approach ~~s. 6(a)~~ the target vessel; this was the windward side,⁷⁰ and as such conditions were more challenging.⁷¹ The RHIB approached ~~s. 6(a)~~ and proceeded alongside to the tag position.⁷² ~~s. 6(a)~~ (the coxswain) reported that he was able to get alongside and maintain his position effectively;⁷³ the challenge was comparable to what he had experienced during recent RHIB to RHIB training⁷⁴. ~~s. 6(a)~~ (navigator) commented that it took approximately ~~s. 6(a)~~ to establish a stable position, which was a little longer than average but commensurate with the fact this was a windward tag.⁷⁵
50. (U) The tag position was adjacent to ~~s. 6(a)~~ on the MV Olivia Maersk (Fig 4), with the coxswain maintaining his position ~~s. 6(a)~~⁷⁶. This position was ~~s. 6(a)~~⁷⁷ affording a good point to maintain a stable position alongside. ~~s. 6(a)~~ had a good view of the approach from his position on board the MV Olivia Maersk and described the positioning of the RHIB as executed with a little bit of difficulty but nothing out of the ordinary for this sort of operation.⁷⁸
51. (U) ~~s. 6(a)~~ worked together to keep the RHIB in the correct position with ~~s. 6(a)~~. This was complicated by a loss of radio communication between them due to the coxswain's headset becoming disconnected during the final approach, but communication was nonetheless effective.⁷⁹

⁷⁰ Witness 1, 2 November 2017, Q28.

⁷¹ Witness 9, 1 November 2017, Q60.

⁷² Witness 18, 2 November 2017, Q35-36; Witness 9, 1 November 2017, Q56.

⁷³ Witness 18, 2 November 2017, Q39.

⁷⁴ Witness 18, 2 November 2017, Q40.

⁷⁵ Witness 9, 1 November 2017, Q60.

⁷⁶ Witness 18, 2 November 2017, Q38; Exhibit BC; Witness 9, 1 November 2017, Q57-58; Witness 6, 1 November 2017, Q19; Exhibit Y.

⁷⁷ Witness 9, 1 November 2017, Q57; Witness 2, 30 October 2017, Q45-47.

⁷⁸ Witness 3, 31 October 2017, Q39-49.

⁷⁹ Conning is the technical term for steering a vessel.

⁸⁰ Witness 18, 2 November 2017, Q34 and 44.

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s. 6(a)

s. 6(a)

52. (U) When ~~s. 6(a)~~ was happy that the RHIB was in a good stable position, he gave the order to commence the tag.⁸²
53. (U) ~~s. 6(a)~~ was responsible for operating the ~~s. 6(a)~~ and at this time he moved into position and attempted to ~~s. 6(a)~~. He found the conditions quite challenging as this was the first time he had ~~s. 6(a)~~.⁸³ ~~s. 6(a)~~ reported the RHIB was surging up and down by about a metre and that the change in angle of attack of the RHIB against the hull of the target vessel was slightly more significant than the heaving motion.⁸⁴ ~~s. 6(a)~~ the Group Commander in RHIB and an operator with D Squadron for over 3 years,⁸⁵ observed the conditions on both sides of the vessel and concluded that, whilst conditions on the ~~s. 6(a)~~ side were slightly worse, the sea state was still quite good.⁸⁶
54. (U) The actual tagging of the ship was assisted by ~~s. 6(a)~~ the Ship Safety Officer. After watching for a period, he assessed that, to expedite the exercise and ensure a safe, secure tag, a small amount of assistance was appropriate.⁸⁷ ~~s. 6(a)~~

⁸¹ Exhibit Q, p 5.

⁸² Witness 9, 1 November 2017, Q63 and Q59.

⁸³ Witness 8, 1 November 2017, Q37-42.

⁸⁴ Witness 6, 1 November 2017, Q30-31.

⁸⁵ Witness 21, 21 November 2017, Q3.

⁸⁶ Ibid Q28

⁸⁷ Witness 3, 31 October 2017, Q49.

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s. 6(a)

Having done this, he attached the safety strop to a lower guardrail and gave the signal for climbers to begin the ascent of the ladder.⁸⁹ Due to the conditions in the RHIB, s. 6(a) checked 3 times with the Navigator that he was happy the RHIB was positioned stably. Having verified this and satisfied himself the team were ready, he gave the command to climb.⁹⁰

55. s. 6(a) personnel climbed the ladder to board the MV Olivia Maersk ahead of SGT Taylor. Although there were minor discrepancies as to the order in which people climbed,⁹¹ the Court finds that the order of the climbers was s. 6(a) and SGT Taylor.⁹² This finding is due to the weight placed on Witness 7's recollection that he was s. 6(a) climber.

56. s. 6(a)

There are no anti twist devices on the ladder.¹⁰¹

⁸⁸ Witness 3, 31 October 2017, Q49; Witness 6, 1 November 2017, Q19-21; Exhibit X.

⁸⁹ Witness 8, 1 November 2017, Q60.

⁹⁰ Witness 6, 1 November 2017, Q29.

⁹¹ s. 6(a)

⁹² Witness 6, 1 November 2017, Q35; Witness 7, 1 November 2017, Q31.

⁹³ Witness 42, 14 December 2017, Q6.

⁹⁴ Witness 42, 14 December 2017, Q7.

⁹⁵ Exhibit DS; Exhibit DT.

⁹⁶ Exhibit Q, p 37-38, Photos 51-52.

⁹⁷ Exhibit Q, p 39, Photo 53; Exhibit DT.

⁹⁸ Exhibit DU; Exhibit Q, p 39, Photo 54 and p 40, Photo 56.

⁹⁹ Exhibit Q, p 39, Photo 54.

¹⁰⁰ Ibid.

¹⁰¹ Exhibit Q, p 37-38, Photos 51-52.

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s. 6(a)

s. 6(a)

Fig 5 Views of Ladder

57. ~~RR~~ The standard operating procedure for tagging¹⁰² calls for one person (the ladder man) to hold the bottom of the ladder in order to put weight on it as the climbers start.¹⁰³ ~~s. 6(a)~~ commented that during this exercise the conditions made it difficult for the ladder man to maintain weight on the ladder at all times.¹⁰⁴ When it is the ladder man's turn to climb, ~~s. 6(a)~~ takes over this duty.¹⁰⁵ ~~s. 6(a)~~ the ladder man, reported handing this duty to SGT Taylor.¹⁰⁶ However, on the strength of ~~s. 6(a)~~ evidence, the Court finds that he in fact handed the ladder to ~~s. 6(a)~~ ~~s. 6(a)~~

¹⁰² Exhibit DV.

¹⁰³ Witness 6, 1 November 2017, Q33; Witness 14, 3 November 2017, Q2.

¹⁰⁴ Witness 8, 1 November 2017, Q60.

¹⁰⁵ Witness 9, 1 November 2017, Q75.

¹⁰⁶ Witness 14, 3 November 2017, Q8-9.

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s. 6(a)

58. (R) During interviews, the Court asked the climbers to describe the difficulty of the climb. Their responses varied, particularly in light of their individual experience levels,¹⁰⁹ but the following represents some of their comments:

- a. s. 6(a) estimated it took s. 6(a) to climb the ladder.¹¹⁰ He paused once to adjust a face mask after being splashed by a wave¹¹¹ and rated the climb as out of 10 for difficulty.
- b. s. 6(a) described s. 6(a) as battling at the bottom of the ladder but expressed that was normal.¹¹² He rated the difficulty of the tag and climb as out of 10,¹¹³ one of the harder ones he had experienced. He described conditions getting onto the ladder as challenging,¹¹⁴ but once a climber started below the additional weight on the ladder made the second half of the climb easier.¹¹⁵ s. 6(a) indicated that he was able to climb the ladder without the ship's hull causing undue problems.¹¹⁶
- c. s. 6(a) had fewer issues getting onto the ladder¹¹⁷ but found that, at one point, he became stuck between the ladder and the ship's hull and had to flip himself back round.¹¹⁸ He rated the climb as out of 10 for difficulty, describing it as "a rough, hard climb".¹¹⁹
- d. s. 6(a) the Group Commander, rated the climb as s. 6(a) out of 10 but commented it was slightly easier than one conducted during a similar exercise earlier in the year.¹²⁰ He had considered the conditions and was comfortable that the climb was manageable for his group.¹²¹ It took him about s. 6(a) to climb the ladder.¹²² He started with his back against the ship before pivoting round the ladder as it jammed up against the hull.¹²³

¹⁰⁷ Witness 8, 1 November 2017, Q56.

¹⁰⁸ Witness 6, 1 November 2017, Q39; Exhibit F, Tag & Climb para 3

¹⁰⁹ Generally, the more inexperienced members described it as a hard climb while the more experienced members noted it was much easier than many climbs the unit had conducted in the past.

¹¹⁰ Witness 15, 3 November 2017, Q53.

¹¹¹ Witness 15, 3 November 2017, Q54.

¹¹² Witness 8, 1 November 2017, Q49.

¹¹³ Ibid Q45.

¹¹⁴ Ibid Q50-54.

¹¹⁵ Ibid Q56.

¹¹⁶ Ibid Q58.

¹¹⁷ Witness 16, 3 November 2017, Q26.

¹¹⁸ Witness 16, 3 November 2017, Q22; Witness 7, 1 November 2017, Q32.

¹¹⁹ Witness 16, 3 November 2017, Q19-20.

¹²⁰ Witness 6, 1 November 2017, Q42.

¹²¹ Ibid Q43.

¹²² Ibid Q41.

¹²³ Ibid Q41.

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- e. ~~s. 6(a)~~ for whom this was his first underway tag,¹²⁴ reported the level of difficulty as out of 10.¹²⁵ He initially had his back to the hull and then spun around to face the hull before climbing to the top.¹²⁶ Despite this being his first tag, he felt the climb was achievable.¹²⁷ He reported that, in discussion with some of the other climbers immediately following the incident, the consensus was that it wasn't an easy climb.¹²⁸
- f. ~~s. 6(a)~~ was the climber immediately ahead of SGT Taylor and, as the ladder man, had been maintaining tension on the ladder for other climbers.¹²⁹ He reported conditions in the RHIB as "pretty rough" with water splashing his face.¹³⁰ He rated the difficulty as a ~~s. 6(a)~~ out of 10.¹³¹ While part way up the climb, he felt a big jolt,¹³² and he twisted on the ladder through 360 degrees.¹³³ The climb became more difficult after this point,¹³⁴ and as he reached the top he realised that the guard rail onto which the ladder had been attached had deformed significantly.¹³⁵
59. (R) Other witnesses had differing perspectives on the difficulty of the climb, with this difference likely related to their experience and vantage point:
- From his position on board the MV Olivia Maersk, ~~s. 6(a)~~ with limited experience of underway tags,¹³⁶ reported that his overall impression was of a challenging climb.¹³⁷ He noted that climbers took between ~~s. 6(a)~~ to climb the ladder.¹³⁸
 - ~~s. 6(a)~~ the Navigator of RHIB – with two and a half years with D Squadron¹³⁹ and sufficient experience to feel fully confident in his role¹⁴⁰ noted the conditions could look intimidating,¹⁴¹ but in his experience this was normal, and conditions were around out of 10 for difficulty.¹⁴²

¹²⁴ Witness 7, 1 November 2017, Q7.

¹²⁵ Ibid Q55.

¹²⁶ Ibid Q32.

¹²⁷ Ibid Q52-54.

¹²⁸ Ibid Q61.

¹²⁹ Witness 14, 3 November 2017, Q2.

¹³⁰ Witness 14, 3 November 2017, Q7-8.

¹³¹ Ibid Q20.

¹³² Ibid Q14.

¹³³ Ibid Q22.

¹³⁴ Ibid Q20.

¹³⁵ Ibid Q16.

¹³⁶ Witness 29, 22 November 2017, Q4.

¹³⁷ Ibid Q11.

¹³⁸ Ibid Q12.

¹³⁹ Witness 9, 1 November 2017, Q3.

¹⁴⁰ Ibid Q13-14.

¹⁴¹ Ibid Q70.

¹⁴² Ibid Q71-74.

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- c. ~~s. 6(a)~~ the Ship Safety Officer who has been with D Squadron for eight years, acknowledged that the conditions were such that particularly at the start of the climb personnel were getting splashed by the waves. However, given the vessel was travelling at around ~~s. 6(a)~~ he noted that the conditions were not at all out of the ordinary.¹⁴³
- d. ~~s. 6(a)~~ D Squadron ~~s. 6(a)~~ was confident that the conditions alongside were adequate for there to be no concerns around the activity being conducted safely.¹⁴⁴
60. (U) Having examined the evidence of all those who climbed the ladder or observed the climb, the Court finds that, whilst the level of difficulty was challenging and towards the upper limit, it remained firmly within what would normally be expected of Special Forces Operators at OLOC.
61. (U) While the final two climbers were on the ladder, the guardrail onto which the ladder was attached failed. It deformed in the centre without fully snapping,¹⁴⁵ dropping by approximately 10 cm¹⁴⁶ (see Fig 6). ~~s. 6(a)~~ was standing over the guardrail as it failed; he heard a crack and, seeing the rail bending, instinctively grabbed ~~s. 6(a)~~ to provide extra support. He checked the safety strop was in place, which it was ~~s. 6(a)~~¹⁴⁷ and adjusted his position to allow him to grasp the ladder and exert his full force to provide support.¹⁴⁸
~~s. 6(a)~~

¹⁴³ Witness 3, 31 October 2017, Q42-49.

¹⁴⁴ Witness 2, 30 November 2017, Q49.

¹⁴⁵ Witness 3, 31 October 2017, Q51.

¹⁴⁶ Witness 3, 31 October 2017, Q54; Exhibit Q, p 8-22.

¹⁴⁷ Witness 6, 1 November 2017, Q50-51; Exhibit X, photo 10.

¹⁴⁸ Witness 6, 1 November 2017, Q50.

¹⁴⁹ Exhibit Q, p 13.

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62. (U) ~~s. 6(a)~~ the Ship Safety Officer, informed ~~s. 6(a)~~ the RHIB Safety Officer, of the incident and ordered no more climbers to mount the ladder,¹⁵⁰ but, at the time the guardrail had failed, SGT Taylor, the final climber, was already on the ladder and committed to the climb.¹⁵¹ As ~~s. 6(a)~~ completed his climb, he was ordered to remove his pistol belt and improvise an additional safety strop on the ladder.¹⁵²

63. (U) As SGT Taylor began his climb from the RHIB, his foot was trapped for 30-40 seconds by the twisting ladder ~~s. 6(a)~~ now acting as ladder man, assisted him in freeing it, and SGT Taylor continued the climb.¹⁵³ As SGT Taylor continued the climb, his pace became noticeably slower than the other climbers, and, about halfway up the ladder, he came to a stop.¹⁵⁴

~~s. 6(a)~~

(U) Fig 7 Disposition of personnel prior to SGTT Taylor's fall from ladder¹⁵⁵

64. (U) It is unclear why SGT Taylor stopped:

a. ~~s. 6(a)~~ observing from the bottom of the ladder, thought it may have been fatigue but was uncertain.¹⁵⁶

¹⁵⁰ Witness 3, 31 October 2017, Q51; Witness 2, 30 October 2017, Q58; Witness 6, 1 November 2017, Q60.

¹⁵¹ Witness 2, 30 October 2017, Q58. That is to say turning back would have meant more time on the ladder (thus being a more dangerous option) than completing the climb.

¹⁵² Witness 14, 3 November 2017, Q16; Witness 6, 1 November 2017, Q63.

¹⁵³ Witness 9, 1 November 2017, Q77.

¹⁵⁴ Witness 9, 1 November 2017, Q77; Witness 29, 22 November 2017, Q14.

¹⁵⁵ Witness 7, 1 November 2017, Q39-40; Exhibit AB; Witness 6, 1 November 2017, Q60-65; Exhibit X, photo 9; Witness 15, 3 November 2017, Q20-29; Exhibit AV.

¹⁵⁶ Witness 9, 1 November 2017, Q77.

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- b. ~~s. 6(a)~~ observing from the top of the ladder, first saw SGT Taylor halfway up the ladder and already stationary.¹⁵⁷ He felt that SGT Taylor may have been snagged, as he was repeatedly cursing whilst adjusting his position without moving up or down.¹⁵⁸
65. (U) Witnesses in the safety RHIB had a clear view of climbers on the ladder from approximately 50m away.¹⁵⁹ They confirmed that SGT Taylor was having some difficulty with the climb and had come to a stop for as much as 60-90 seconds, approximately a body length from the ship's gunwale or 4-5m from the water.¹⁶⁰ He was observed to climb down a rung, although these witnesses were uncertain if this was due to fatigue and an attempt to abort the climb or in an effort to disentangle himself from the ladder.¹⁶¹
66. (U) Two witnesses saw SGT Taylor on the ladder from astern:
- ~~s. 6(a)~~ in RHIB approximately 100m behind RHIB¹⁶² reported SGT Taylor as stopping and moving up and down about a rung about midway up the side of the ship.¹⁶³
 - ~~s. 6(a)~~ on board MV Olivia Maersk was the ~~s. 6(a)~~ safety number and had moved to ~~s. 6(a)~~ continue to observe RHIB █ as it manoeuvred to that side.¹⁶⁴ Observing from ~~s. 6(a)~~
¹⁶⁵ he reported that SGT Taylor seemed to be struggling, being turned around quite a lot on the ladder especially being the last person. About halfway up he paused for what seemed a long time before what looked like an attempt to descend.¹⁶⁶
67. (U) In the opinion of the Court, ~~s. 6(a)~~ who was looking directly over the guardrail, had the best view. Once ~~s. 6(a)~~ had cleared the ladder, ~~s. 6(a)~~ had a clear view down to SGT Taylor. He gave the following evidence:
- The ladder was twisting at the bottom since it only had one person on it, and it appeared that SGT Taylor was getting into difficulty.¹⁶⁷
 - It appeared that SGT Taylor's foot had become caught in the ladder and that he was holding on in that position.¹⁶⁸

¹⁵⁷ Witness 15, 3 November 2017, Q20-23; Exhibit AV, position B.

¹⁵⁸ Witness 15, 3 November 2017, Q25.

¹⁵⁹ Witness 17, 3 November 2017, Q18; Witness 2, 30 October 2017, Q42; Exhibit I; Witness 19, 3 November 2017, Q39; Witness 12, 2 November 2017, Q23.

¹⁶⁰ Witness 2, 30 October 2017, Q58; Witness 17, 3 November 2017, Q21-22; Exhibit AY.

¹⁶¹ Witness 2, 31 October 2017, Q90; Witness 1, 30 October 2017, Q63; Witness 12, 2 November 2017, Q29.

¹⁶² Witness 26, 21 November 2017, Q27-28.

¹⁶³ Witness 26, 21 November 2017, Q31-33; Exhibit BJ.

¹⁶⁴ Witness 29, 22 November 2017, Q9.

¹⁶⁵ Witness 29, 22 November 2017, Q13; Exhibit BK.

¹⁶⁶ Witness 29, 22 November 2017, Q14.

¹⁶⁷ Witness 3, 31 October 2017, Q66.

¹⁶⁸ Ibid Q66.

- c. He could hear SGT Taylor becoming audibly frustrated as he tried to kick his right foot free of the ladder.¹⁶⁹
 - d. He kept his eyes on SGT Taylor throughout this period.¹⁷⁰
 - e. ~~s. 6(a)~~ called down to ask if SGT Taylor was OK. He got no response as SGT Taylor was focussed on trying to free himself from the obstruction.¹⁷¹
 - f. As SGT Taylor cleared his foot from the ladder, he began to descend by one rung. ~~s. 6(a)~~ could not be sure if SGT Taylor was trying to reposition his body.¹⁷²
 - g. SGT Taylor appeared to have full freedom of motion up and down the ladder, and ~~s. 6(a)~~ concluded that it was the rotation of the ladder that had trapped a foot.¹⁷³
 - h. ~~s. 6(a)~~ was confident that SGT Taylor had freed his foot, but approximately 10 seconds later he fell.¹⁷⁴
 - i. He concluded that ultimately it was fatigue that had caused SGT Taylor to release from the ladder rather than a technical issue.¹⁷⁵
68. (U) With one exception,¹⁷⁶ the witnesses who saw SGT Taylor fall report consistently that he simply released from the ladder hands first and fell backwards towards the RHIB:¹⁷⁷
- a. ~~s. 6(a)~~ at the bottom of the ladder could not tell why SGT Taylor climbed down but thought it may have been fatigue.¹⁷⁸ He didn't notice any part of SGT Taylor as being snagged¹⁷⁹ and gave evidence that SGT Taylor had released his grip without scrambling.¹⁸⁰ ~~s. 6(a)~~ concurred with this.¹⁸¹
 - b. At the top of the ladder ~~s. 6(a)~~ further noted that, almost at the instant of taking a step down, SGT Taylor fell backwards from the ladder almost directly down into the RHIB.¹⁸²
 - c. The only variation from this description was from ~~s. 6(a)~~ who described some "false grabs on the ladder with his feet and hands".¹⁸³

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

¹⁷¹ Ibid Q83-85.

¹⁷² Ibid Q66.

¹⁷³ Ibid Q86-93.

¹⁷⁴ Witness 3, 31 October 2017, Q95-97.

¹⁷⁵ Ibid Q98-101.

¹⁷⁶ Witness 12, 2 November 2017, Q29.

¹⁷⁷ Witness 1, 30 October 2017, Q63-66; Witness 2, 30 October 2017, Q59; Witness 3, 31 October 2017, Q66; Witness 9, 1 November 2017, Q78; Witness 15, 3 November 2017, Q28-35; Witness 26, 21 November 2017, Q33.

¹⁷⁸ Witness 9, 1 November 2017, Q79.

¹⁷⁹ Ibid Q81.

¹⁸⁰ Ibid Q85.

¹⁸¹ Witness 29, 22 November 2017, Q14.

¹⁸² Witness 3, 31 October 2017, Q67.

¹⁸³ Witness 12, 2 November 2017, Q29.

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69. (U) After considering the evidence presented and giving weight to those closest to the accident with the best vantage point, the Court finds that, following a challenging climb having at least twice had to free his feet from entanglement, SGT Taylor involuntarily released his grip due to fatigue in his hands and forearms thus falling from the ladder.
70. (U) Having let go of the ladder, SGT Taylor was seen by five witnesses to fall backwards into the RHIB striking the ~~s. 6(a)~~ in the vicinity of the mast:
- a. ~~s. 6(a)~~ in the RHIB and ~~s. 6(a)~~ at the top of the ladder both saw him fall backwards in the vicinity of the mast with his head in board (in relation to the RHIB) but could not confirm he struck his head.¹⁸⁴
 - b. ~~s. 6(a)~~ reported that SGT Taylor struck the RHIB just forward of the mast.¹⁸⁵
 - c. ~~s. 6(a)~~ observing from above reported seeing SGT Taylor strike the RHIB approximately adjacent to the mast¹⁸⁶ though he only had a split second view.¹⁸⁷
 - d. ~~s. 6(a)~~ with a good view from above reported seeing SGT Taylor fall backwards and strike the RHIB on the ~~s. 6(a)~~ pontoon slightly forward of the mast,¹⁸⁸ though couldn't recall how Taylor was orientated as he struck.¹⁸⁹
~~s. 6(a)~~

71. (U) As soon as it was clear what had happened, ~~s. 6(a)~~ the coxswain of RHIB began to manoeuvre in anticipation of recovering SGT Taylor.¹⁹¹

¹⁸⁴ Witness 3, 31 October 2017, Q67-80; Exhibit O; Witness 9, 1 November 2017, Q88-92 and Q117; Exhibit AG.

¹⁸⁵ Witness 29, 22 November 2017, Q17-21; Exhibit BL.

¹⁸⁶ Witness 6, 1 November 2017, Q68-78; Exhibit Z.

¹⁸⁷ Witness 6, 1 November 2017, Q77.

¹⁸⁸ Witness 15, 3 November 2017, Q34-40; Exhibit AW.

¹⁸⁹ Witness 15, 3 November 2017, Q39.

¹⁹⁰ Exhibit Q, p 68.

¹⁹¹ Witness 18, 3 November 2017, Q48.

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In the Safety RHIB, the coxswain also began to manoeuvre to provide assistance.¹⁹²

72. (U) From the moment that SGT Taylor entered the water, he was observed almost constantly until recovery by personnel in RHIB¹⁹³. No witnesses reported any signs that he was conscious. Specifically, the following personnel gave evidence:

- a. In RHIB saw SGT Taylor bounce off the pontoon and into the water. He was looking over the side and saw that SGT Taylor did not get crushed between the RHIB and the hull of the MV Olivia Maersk nor come into contact with the RHIB's propellers.¹⁹⁴ He recalled that the distance between the RHIB and the hull of the ship was approximately 1.5m.¹⁹⁵
- b. Viewing from above, ~~s. 6(a)~~ noted that, having bounced off the pontoon, SGT Taylor did not appear to come into contact with the RHIB or ship,¹⁹⁶ although he did briefly lose sight of SGT Taylor between bouncing off the pontoon and then seeing him in the water.¹⁹⁷ ~~s. 6(a)~~ evidence was the gap between the vessels was about 1m.¹⁹⁸ On initial entry into the water, ~~s. 6(a)~~ briefly saw SGT Taylor appearing to float in a head up or vertical position.¹⁹⁹
- c. Once clear of RHIB personnel on the upper deck of the ship followed SGT Taylor's progress in the water.²⁰⁰ ~~s. 6(a)~~ had the best unobstructed view and was able to monitor SGT Taylor as he passed down the side of the ship. His immediate sense was that SGT Taylor was unconscious, floating on his back; as SGT Taylor passed through the wake, ~~s. 6(a)~~ felt he had seen a hand raised but in hindsight feels what he saw was an unconscious man being turned by the turbulent water.²⁰¹
- d. ~~s. 6(a)~~ also saw SGT Taylor floating horizontally but could not discern if he was on his front or back. He watched him float all the way down the ship's side about 2m off and did not see him come into contact with the ship.²⁰²
- e. ~~s. 6(a)~~ in RHIB having lost sight of the man as he fell, spotted him again as he came through the wake of the MV Olivia Maersk. Initially, he just saw a

¹⁹² Witness 12, 2 November 2017, Q37.

¹⁹³ ~~s. 6(a)~~ gave evidence of viewing him from entry into the water until clear of the RHIB. ~~s. 6(a)~~ gave evidence of viewing him from clearing the RHIB until partially down the ship's side. ~~s. 6(a)~~ gave evidence of viewing him from entry into the water until he had passed through the ship's stern wave. ~~s. 6(a)~~ and ~~s. 6(a)~~ gave evidence of viewing him from passing through the stern wave to the recovery.

¹⁹⁴ Witness 9, 1 November 2017, Q88.

¹⁹⁵ Ibid Q93-94.

¹⁹⁶ Witness 6, 1 November 2017, Q73-75.

¹⁹⁷ Ibid Q76-77.

¹⁹⁸ Ibid Q75.

¹⁹⁹ Ibid Q79.

²⁰⁰ Witness 3, 31 October 2017, Q103.

²⁰¹ Witness 29, 22 November 2017, Q22-26.

²⁰² Witness 15, 2 November 2017, Q44 -52.

dark object, but as soon as it was close enough he made out an unconscious figure floating face-down in the water.²⁰³

f. ~~s. 6(a)~~ recalls first sighting SGT Taylor about 30 seconds after the alarm was raised that someone had fallen. He was floating face-down positively buoyant but with his life jacket not inflated.²⁰⁴ Evidence of other witnesses in RHIB is consistent with these observations,²⁰⁵ although ~~s. 6(a)~~ initially caught sight of SGT Taylor's head and shoulders out of the water, by the time the RHIB was alongside him he was face down.²⁰⁶

73. (U) RHIB from its position astern of RHIB made an approach to recover SGT Taylor from the water ~~s. 6(a)~~

²⁰⁷ On the approach, ~~s. 6(a)~~umped into the sea in order to get SGT Taylor's head out of the water quickly.²⁰⁸ Very shortly thereafter, the RHIB came alongside, and ~~s. 6(a)~~ leant over and activated SGT Taylor's life jacket.²⁰⁹ ~~s. 6(a)~~ then entered the water to assist getting SGT Taylor into the RHIB ~~s. 6(a)~~

personnel in the bow had recovered SGT Taylor into the RHIB.²¹⁰ ~~s. 6(a)~~ was recovered by RHIB which had by this stage arrived at the scene.²¹¹

74. (U) The court finds that, having fallen from the ladder, SGT Taylor struck RHIB with sufficient force to render him unconscious and, taking into consideration witness accounts and GPS timing data available from the safety RHIB, that the time he was in the water unassisted was between one and a half to two minutes.²¹²

Cause of Death

75. (U) The Court finds that SGT Taylor drowned after being knocked unconscious as a result of a fall from approximately 5m whilst attempting to board the MV Olivia Maersk.

²⁰³ Witness 26, 21 November 2017, Q36.

²⁰⁴ Witness 5, 31 October 2017, Q72.

²⁰⁵ Witness 11, 2 November 2017, Q57; Witness 21, 21 November 2017, Q31; Witness 25, 21 November 2017, Q32; Witness 41, 14 December 2017, Q39-40.

²⁰⁶ Witness 13, 2 November 2017, Q94 and 104.

²⁰⁷ Ibid Q103.

²⁰⁸ Witness 22, 21 November 2017, Q22; Witness 11, 2 November 2017, Q57.

²⁰⁹ Witness 21, 21 November 2017, Q34.

²¹⁰ Witness 11, 2 November 2017, Q57-58; Witness 21, 21 November 2017, Q35.

²¹¹ Witness 18, 3 November 2017, Q48.

²¹² Witness 12, 2 November 2017, Q47-51; Exhibit AP; Witness 5, 31 October 2017, Q72. Exhibit BF contains a note made at the time of the accident "found face down after 1 to 2 minutes".

76. (U) The medical evidence provided in the autopsy and by the pathologist is consistent with salt water drowning.²¹³ The pathologist indicated that certain elements within this evidence supported the conclusion that SGT Taylor inhaled large quantities of sea water.²¹⁴ The Court places significant weight on this evidence.
77. (U) Eye witness evidence supports the conclusion that, having fallen, SGT Taylor struck the RHIB he had climbed from²¹⁵ and entered the water unconscious.²¹⁶ The evidence from the autopsy and from the pathologist confirmed that injuries to the head were consistent with a fall from height.²¹⁷ Whilst it was not possible to confirm clinically that SGT Taylor was unconscious when he entered the water,²¹⁸ the Coronial Autopsy Report states "*The injuries to the head may be sustained during the fall and an element of unconsciousness would not be unexpected*";²¹⁹ the pathologist reiterated this in his evidence.²²⁰
78. (U) The Court finds that, prior to his fall, SGT Taylor was conducting activities with sufficient rigour to elevate his breathing rate to a high level;²²¹ all witnesses who had performed the climb ahead of him commented on its demanding nature.²²² The pathologist observed that 12 breaths can be sufficient to cause drowning for a normal person;²²³ with a high breathing rate, it is likely SGT Taylor quickly inhaled large quantities of sea water that made it unlikely that he could have been revived unless immediately recovered from the water.²²⁴

Immediate and Subsequent Casualty Treatment

79. (U) The Court finds that all medical treatment given to SGT Taylor was of a high standard and compliant with Defence Medical Treatment Protocols.²²⁵
80. (U) The Court further finds that no further treatment could reasonably have been provided to SGT Taylor under the circumstances.

²¹³ Witness 43, 14 December 2017, Q5; Exhibit CR, p 1 para 3.

²¹⁴ Witness 43, 14 December 2017, Q15-16.

²¹⁵ See para 70.

²¹⁶ See para 71-73.

²¹⁷ Exhibit CR, p 4 para 2.

²¹⁸ Witness 43, 14 December 2017, Q7.

²¹⁹ Exhibit CR, p 4 para 2.

²²⁰ Witness 43, 14 December 2017, Q7.

²²¹ See para 64-67

²²² See para 58.

²²³ Witness 43, 14 December 2017, Q14.

²²⁴ Ibid.

²²⁵ Witness 32, 22 November 2017, Q8-19; Witness 5, 31 October 2017, Q121.

81. (U) Upon recovering SGT Taylor from the water, the embarked assault group immediately initiated resuscitation efforts. Simultaneously, the Safety RHIB made its way to the point of recovery. Upon arrival up of the s. 6(a) RHIBS, s. 6(a) (the D Squadron medic) was transferred to RHIB to provide primary medical care.²²⁶ s. 6(a) assessed that the transfer of the medic probably occurred at approximately 0615.²²⁷ At this point, SGT Taylor was being treated at the front of RHIB by up to three assault group members.²²⁸ s. 6(a) and 9(2)(a)

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82. (U) Whilst members of the assault group removed SGT Taylor's equipment and clothing, s. 6(a) and 9(2)(a)

²³⁰ As there was insufficient room at the front of the RHIB in which to perform resuscitation, s. 6(a) ordered the rear of the RHIB to be cleared and had SGT Taylor moved to that location.²³¹

s. 6(a) and 9(2)(a)

²³⁴ and one described paint on the back of his bump helmet²³⁵ consistent with that on the MV Olivia Maersk indicating that the helmet had been in contact with the hull of the ship.

84. (U) s. 6(a) commenced further treatment of SGT Taylor by checking his airway for obstructions and checking his breathing.²³⁶ Soldiers commenced Cardio Pulmonary Resuscitation (CPR); this was recorded by s. 6(a) as occurring at 0610.²³⁷ s. 6(a) recalled that he began filling in Exhibit BF, the Medical Evacuation Card, sometime between CPR commencing s. 9(2)(a)

²²⁶ Witness 20, 21 November 2017, Q39.

²²⁷ Witness 12, 2 November 2017, Q56; Exhibit AP, Position C.

²²⁸ Witness 12, 2 November 2017, Q40.

²²⁹ Witness 23, 21 November 2017, Q35; Witness 41, 14 December 2017, Q42.

²³⁰ Witness 20, 21 November 2017, Q40.

²³¹ Ibid

²³² Ibid, Q42.

²³³ Witness 21, 21 November 2017, Q43; Witness 23, 21 November 2017, Q36; Witness 27, 21 November 2017, Q26.

²³⁴ Witness 27, 21 November 2017, Q26.

²³⁵ Witness 21, 21 November 2017, Q43.

²³⁶ Witness 20, 21 November 2017, Q42.

²³⁷ Witness 20, 21 November 2017, Q42; Witness 21, 21 November 2017, Q52-53; Exhibit BF.

²³⁸ Witness 21, 21 November 2017, Q52-62; Exhibit BF.

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85. (U) The Court finds that approximately three minutes elapsed from when ~~s. 6(a)~~ transferred to RHIB and CPR commenced.²³⁹
86. (U) Taking into account the more accurate timing data provided by ~~s. 6(a)~~ of when ~~s. 6(a)~~ transferred to RHIB²⁴⁰ the Court finds that the actual time CPR commenced was approximately 0618. The Court further finds that timings from Exhibit BF become accurate from 0630 onwards.
~~s. 6(a), 9(2)(a)~~
- 87.

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the RHIB made way to the evacuation point, the assault group cycled through chest compressions initially at two-minute intervals,²⁴³ this was then reduced to one-minute intervals due to the fatiguing effect of the RHIB in transit.²⁴⁴ ~~s. 6(a)~~ comments that the speed of the boat was reasonable²⁴⁵ and that CPR was being conducted effectively²⁴⁶ at no more than two minute cycles per person.²⁴⁷ Approximately 10 minutes into the CPR, ~~s. 6(a), 9(2)(a)~~

88. (U) During the transit, in consultation with the crew of the WESTPAC Rescue Helicopter, ~~s. 6(a)~~ made the decision to make for Port Jackson.²⁵⁰ CPR continued until arrival at approximately 0710.²⁵¹ At this point, SGT Taylor was transferred ashore while a party was sent to identify and mark a helicopter landing point.²⁵² The WESTPAC Rescue Helicopter out of Mechanics Bay arrived at 0715²⁵³ and responsibility for treatment was handed over to the paramedics.²⁵⁴ Assault group personnel continued to

²³⁹ Witness 20, 21 November 2017, Q42.

²⁴⁰ Witness 12, 2 November 2017, Q56; Exhibit AP, Position C.

²⁴¹ Witness 20, 21 November 2017, Q42-43.

²⁴² Witness 20, 21 November 2017, Q43-44.

²⁴³ Ibid, Q44.

²⁴⁴ Ibid.

²⁴⁵ Ibid, Q45.

²⁴⁶ Ibid, Q47.

²⁴⁷ Ibid.

²⁴⁸ Ibid, Q49; Exhibit BF.

²⁴⁹ Witness 20, 21 November 2017, Q57.

²⁵⁰ Witness 5, 31 October 2017, Q77.

²⁵¹ Witness 1, 30 October 2017, Q77; Exhibit AI, p 8.

²⁵² Witness 2, 30 October 2017, Q77.

²⁵³ Witness 20, 21 November 2017, Q52; Witness 21, 21 November 2017, Q50.

²⁵⁴ Witness 20, 21 November 2017, Q52; Witness 21, 21 November 2017, Q50.

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provide assistance to the resuscitation efforts throughout.²⁵⁵ At 0725, the ambulance arrived followed by the Colville One Response Team (and doctor) at 0735.²⁵⁶ The doctor attending from the Coromandel Saint John's Ambulance pronounced SGT Taylor dead at 0745.²⁵⁷

Other Actions Taken After the Event

89. (U) The Court finds that actions immediately following the accident were in accordance with relevant procedures and orders and that all possible measures were taken in the immediate response to the events of 13 October 2017.
90. (U) The Court finds that casualty notification and reporting associated with the accident was in accordance with standard procedures and that all reports were made accurately and in a timely fashion.
91. (U) As a result of 111 calls by both ~~s. 6(a)~~ and ~~s. 6(a)~~ and subsequent activation of the Safety RHIB's EPIRB,²⁵⁸ the following emergency services responded:²⁵⁹
 - a. WESTPAC Rescue Helicopter out of Mechanics Bay, Auckland; and
 - b. Saint John's Ambulance out of Colville.
92. (U) Due to subsequent calls, other agencies responded, including:²⁶⁰
 - a. New Zealand Police Criminal Investigation Bureau,
 - b. Maritime New Zealand,
 - c. Maritime Police,
 - d. Search and Rescue, and
 - e. NZDF Military Police.

93 ~~s. 6(a)~~

²⁶² The NZSAS Regiment's Operations Staff initiated casualty notification procedures²⁶³ and the ~~s. 6(a)~~ released an e-mail INCIDENTREP (INCIDENTREP 002)²⁶⁴ to the Chief of Staff, HQNZDF (Army). ~~s. 6(a)~~ sought assistance from Northern Region Legal Advisor and

²⁵⁵ Witness 21, 21 November 2017, Q73.

²⁵⁶ Witness 1, 30 October 2017, Q77.

²⁵⁷ Ibid.

²⁵⁸ Exhibit AR.

²⁵⁹ Witness 1, 30 October 2017, Q73.

²⁶⁰ Ibid, Q79.

²⁶¹ Ibid, Q73.

²⁶² Witness 46, 25 January 2018, Q13.

²⁶³ Exhibits DN, DO.

²⁶⁴ Exhibit DJ.

- from s. 9(2)(a) (a previous Regimental Medical Officer (RMO)), who happened to be notified by Search and Rescue.²⁶⁵
94. (U) Safety staff on board the MV Olivia Maersk secured the s. 6(a) ladder and took photographs of the tag point and the failed railing.²⁶⁶ Within Papakura Military Camp, s. 6(a), 9(2)(a) who was acting as the logistics staff officer at the time identified a quarantine area and isolated the equipment used during s. 6(a).²⁶⁷ Personnel involved in the training activity commenced documenting their recollections of the event.²⁶⁸
95. (U) s. 9(2)(a) the General Staff Officer for Health and Safety at Army General Staff, informed Work Safe New Zealand of the fatality (it being a notifiable event) on 13 October 2017. A confirmation e-mail and letter was received back on the same day.²⁶⁹
96. (U) Further notifications by the Regimental Operations and Headquarters staff included a Follow Up Death NOTICAS²⁷⁰ and Safety Reporting System (SRS) reporting.²⁷¹ Two days after the event, Regimental Operations staff sent a QUICKREP.²⁷² The staff also put together a briefing pack for Senior Leaders s. 6(a) Briefing Pack).²⁷³
97. (U) The party left on board the MV Olivia Maersk did not receive any notification of the death of SGT Taylor. The first any of the party heard was via a Short Message Service (SMS) or text message from a cousin of one of those on board²⁷⁴ and then via an online news article.²⁷⁵ On arrival back to Papakura Military Camp, the party received the news that the fatality was SGT Taylor.²⁷⁶ The speed with which information was released to the media was driven by the exposure to the public of the casualty evacuation effort at Port Jackson.²⁷⁷ The Court finds that whilst regrettable, given the circumstances, the balance between informing personnel directly involved in the operation and releasing information to the media was appropriate.

²⁶⁵ Witness 1, 30 October 2017, Q79-80.

²⁶⁶ Witness 3, 31 October 2017, Q103 and Q137; Exhibit AZ, p 3; Exhibit Q, p 3-34.

²⁶⁷ Witness 1, 30 October 2017, Q124.

²⁶⁸ These recollections were included as Exhibits J, W, BG and CQ.

²⁶⁹ Exhibit DF.

²⁷⁰ Exhibit DI.

²⁷¹ Exhibit DG.

²⁷² Exhibit DP.

²⁷³ Exhibit DQ.

²⁷⁴ Witness 31, 22 November 2017, Q26.

²⁷⁵ Witness 31, 22 November 2017, Q26; Witness 29, 22 November 2017, Q31; Witness 30, 22 November 2017, Q13.

²⁷⁶ Witness 28, 22 November 2017, Q11.

²⁷⁷ Witness 46, 25 January 2018, Q17.

98. (U) The Court finds that all personnel directly involved in the accident had sufficient access to counselling and that the support provided by D Squadron and the wider organisation was strong.²⁷⁸

Actions of the MV Olivia Maersk

99. (U) The Court finds that the actions of the MV Olivia Maersk played no part in the cause or subsequent effects of the accident and that the crew acted appropriately in response to the circumstances of the accident.

100. (U) During the approach of the RHIBs towards MV Olivia Maersk, ~~s. 6(a)~~ was located on the bridge of the ship acting as a liaison officer.²⁷⁹ From when the RHIBs began their approach until after the accident had occurred, the ship's log records she maintained a steady course²⁸⁰ on a heading of 289° True.²⁸¹ ~~s. 6(a)~~ reported a speed of ~~s. 6(a)~~ was maintained throughout²⁸² and that the ship did not alter course and appeared to be on auto pilot.²⁸³ Automatic Identification System (AIS) data obtained from Maritime New Zealand confirmed that the ship maintained her course and speed throughout the accident.²⁸⁴

101. (U) ~~s. 6(a)~~ quickly reported the accident to ~~s. 6(a)~~ on the bridge, the Ship's staff asked if there was a requirement for the ship to alter course or speed. ~~s. 6(a)~~ instructed them after consultation with ~~s. 6(a)~~ to maintain their planned course.²⁸⁵

102. (U) Initial reactions from the ship were taken by on watch personnel.²⁸⁶ The Master of the MV Olivia Maersk was informed by his staff after about 15 minutes that there had been a man over board incident, that the man had been recovered and that no assistance was required.²⁸⁷ The vessel then continued its passage to Auckland.²⁸⁸

SGT Taylor's Training and Experience

103. (U) ~~s. 6(a)~~ is the current means/mechanism used to qualify Special Operations Forces (SOF) personnel on the full range of Counter Terrorism (CT) options

²⁷⁸ Witness 12, 2 November 2017, Q91; Witness 6, 1 November 2017, Q122-123; Witness 20, 21 November 2017, Q78-79; Witness 46, 25 January 2018, Q14-15.

²⁷⁹ Witness 31, 22 November 2017, Q5.

²⁸⁰ Witness 45, 21 December 2017, Q7; Exhibit CZ.

²⁸¹ A compass bearing relative to True North as opposed to Magnetic North.

²⁸² Witness 31, 22 November 2017, Q12.

²⁸³ Ibid Q21-23.

²⁸⁴ Witness 10, 2 November 2017, Q9-13; Exhibit AI, p 4-6.

²⁸⁵ Witness 3, 31 October 2017, Q103; Witness 31, 22 November 2017, Q20.

²⁸⁶ Witness 31, 22 November 2017, Q20.

²⁸⁷ Witness 45, 21 December 2017, Q11.

²⁸⁸ Exhibit CZ.

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including MCT activities.²⁸⁹ The tagging and boarding of the MV Olivia Maersk was an MCT activity ^{s. 6(a)} ²⁹⁰
104. ^{s. 9(2)(a)}

²⁹¹ CTTAG was the precursor to D Squadron, and the CTTAG training the precursor to ^{s. 6(a)} The Court concludes that SGT Taylor was suitably qualified to participate in the activity known as ^{s. 6(a)}

105. (U) The Court heard statements from multiple sources and viewed evidence²⁹² which corroborated the assertion that SGT Taylor was one of the most experienced members of D Squadron at MCT operations. Prior to ^{s. 6(a)} SGT Taylor conducted his most recent underway tag during ^{s. 6(a)} on 14 March 2017.²⁹³ The Court finds that SGT Taylor was suitably experienced to participate in the activity known as ^{s. 6(a)}

106. (U) The D Squadron Physical Training Instructor (PTI) provided evidence on SGT Taylor's fitness²⁹⁴ and initial results on the Operator Performance Programme (OPP).²⁹⁵ The OPP is a monitored programme conducted by the PTIs and deals with a wider range of fitness components than single service fitness tests. Components of the OPP include upper body strength, muscular endurance, agility, speed, lactic threshold amongst others.²⁹⁶ The OPP tracks operator fitness levels rather than tests against strict criteria.²⁹⁷ ^{s. 9(2)(a)}

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PTI staff had no concerns about his fitness with regards to the effective conduct of his duties within D Squadron including climbing.³⁰⁰ The Court accepts this assessment.

108. ~~(T)~~ ^{s. 6(a)}

²⁸⁹ Witness 35, 23 November 2017, Q3.

²⁹⁰ Witness 1, 30 October 2017, Q12; Witness 46, 25 January 2018, Q4.

²⁹¹ Enclosure 3 to Exhibit BV.

²⁹² Witness 35, 23 November 2017, Q26; Witness 1, 30 October 2017, Q110; Exhibit BV; Enclosure 3 to Exhibit BV, Witness 50, 04 May 2018, Q46-47 and 51

²⁹³ Witness 5, 18 March 2018, Q4 and Q10; Exhibit DL (Orders for Ex SARACEN boarding of MV BERNHARD S).

²⁹⁴ Witness 39, 24 November 2017, Q11-18.

²⁹⁵ Exhibit CH.

²⁹⁶ Witness 36, 23 November 2017, Q5.

²⁹⁷ Ibid, Q7.

²⁹⁸ Witness 36, 23 November 2017, Q12; Witness 39, 24 November 2017, Q8.

²⁹⁹ Witness 39, 24 November 2017, Q12.

³⁰⁰ Ibid, Q17.

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s. 6(a)

³⁰¹ but that individual experience will play a part in how such training should be conducted.³⁰² The Court concludes that SGT Taylor had a suitable level of currency³⁰³ when compared with the requirements for similar hazardous infiltration activities but notes there is no standing currency requirement.³⁰⁴

109. (U) Having considered the evidence of others who conducted the boarding operation of the MV Olivia Maersk during s. 6(a) the Court finds that the climb onto the MV Olivia Maersk should normally have been within SGT Taylor's ability. The Court finds no evidence of any psychological, familial, emotional or mental wellbeing issues that might have contributed to SGT Taylor's death or that may have impaired his performance in the conduct of his duties at that time.³⁰⁵

D Squadron's Training and Experience

110. (R) The Court finds that the level of training conducted on s. 6(a) to be sufficiently robust to qualify individuals on the skills required to conduct tagging operations underway³⁰⁶ but noted there is no currency requirement as with other infiltration skills such as fast-roping.³⁰⁷

111. (U) The court found that those involved with s. 6(a) were of varying levels of training and experience and some members of the team had not had prior exposure to the level of difficulty anticipated (offshore at night). For three of the team members, it was their first underway tag.³⁰⁸ At the completion of the activity, one member had still to complete an underway tag.³⁰⁹

112. (U) Tagging training is conducted as part of s. 6(a) and consists of a graduated approach moving from practicing on ships alongside before moving to an underway tag.³¹⁰ s. 6(a)

³⁰¹ Witness 35, 23 November 2017, Q10-11.

³⁰² Ibid, Q12

³⁰³ See para 105.

³⁰⁴ Witness 2, Interview 2, Q5; Witness 35, 23 November 17, Q18.

³⁰⁵ Witnesses 34, 23 November 2017, Q4-5; Witness 37, 23 November 2017, Q4-5; Witness 38, 23 November 2017, Q3-5; Witness 39, 24 November 2017, Q18.

³⁰⁶ Witness 35, 23 November 2017, Q3-8; Witness 35, 14 December 2017, Q10-18.

³⁰⁷ Witness 35, 23 November 2017, Q19 and 22; Witness 2, 31 October 2017, Q5.

³⁰⁸ Witness 7, 1 November 2017, Q8; Witness 23, 21 November 2017, Q5-8; Witness 25, 21 November 2017, Q20.

³⁰⁹ Witness 25, 21 November 2017, Q29.

³¹⁰ Witness 42, 14 December 2017, Q19.

³¹¹ Witness 50, 4 May 2018, Q 39-41; Exhibit DV.

s. 6(a)

113. (P) Five of the participants had completed their ~~s. 6(a)~~ training in the same calendar year as the accident (2017) and had done a considerable amount of boarding using ~~s. 6(a)~~ ladders during their ~~s. 6(a)~~ 315 Conversely, one team member had qualified many years prior but had little current experience.³¹⁶
114. (U) The Court notes that those who had qualified more recently reported finding the boarding activity to be well within their capabilities even if difficult.³¹⁷
115. (U) OC SOTC discussed the qualification and currency requirements in general terms and acknowledged that it was up to D Squadron to maintain the level of training required to conduct activities such as ~~s. 6(a)~~ taking into account the individual levels of experience within the unit.³¹⁸ He noted that for an activity of the nature conducted during ~~s. 6(a)~~ ideally a daylight underway tag would have been conducted during the preparation.³¹⁹
116. (U) OC SOTC commented on the culture of individuals monitoring their own currency and competency. He felt personnel were equipped and empowered to raise concerns within the unit if they felt an activity was beyond them.³²⁰
117. (U) The CO 1 NZSAS Regiment acknowledged that there may be a requirement for some individuals to conduct refresher training but that the frequency of MCT Battle Handling Exercises (BHE) met that requirement.³²¹
118. (U) Due to there being no formal policy on training currency for (underway) boarding operations via ~~s. 6(a)~~ ladder, the Court recommends that 1 NZSAS Regiment develop a formalised currency regime.

³¹² Ibid Q19-27.

³¹³ Ibid Q14-18.

³¹⁴ Witness 35, 14 December 2017, Q13.

³¹⁵ Witness 14, 3 November 2017, Q3-6; Witness 22, 21 November 2017, Q4-7; Witness 24, 21 November 2017, Q4-9; Witness 27, 21 November 2017, Q4-10; Witness 41, 14 December 2017, Q8-18.

³¹⁶ Witness 26's last underway tag was in 2014.

³¹⁷ Witness 7, 1 November 2017, Q14-15; Witness 8, 1 November 2017, Q55; Witness 9, 1 November 2017, Q69-74.

³¹⁸ Witness 35, 23 November 2017, Q18-22.

³¹⁹ Witness 35, 14 December 2017, Q2.

³²⁰ Ibid Q7-9.

³²¹ Witness 46, 25 January 2018, Q18-20.

Duties or Activities of Personnel 24 Hours Prior to Accident

119. (P) The court finds that the tempo of activity for D Squadron in the run up to ~~s. 6(a)~~ had been within its usual routine with a general focus on MCT training.³²² The Court further finds that the team's fatigue levels at the commencement of the assault were within normal limits for MCT operations and training.

120. (P) Recent activity had included assault training ~~s. 6(a)~~ which SGT Taylor had supervised;³²⁴ most operators had recently been involved in night training so were used to the routine of overnight exercises.³²⁵ Routines for the Squadron during the week commencing 9 October were based around Auckland with training on the shooting ranges for the snipers³²⁶ and MCT training at Devonport for other members of the assault groups.³²⁷

121. (U) The accident occurred at 0611 on 13 October 2017.³²⁸ Activity in the 24 hours immediately prior can be divided into 3 phases; activity prior to reporting for duty, preparation and briefing and transit to the target vessel. Types of activity can be split between 3 distinct groups, ~~s. 6(a)~~

embarked in the MV Olivia Maersk.

122. (U) Activity prior to reporting for duty. The Court finds that the tempo within D Squadron during the week of the 9 October allowed personnel to be fully rested ahead of ~~s. 6(a)~~ on 12-13 October. Personnel interviewed indicated that the tempo within D Squadron meant that all personnel had the opportunity for a full night's rest before reporting for duty on 12 October.³²⁹ SGT Taylor had not been at work the previous day as he was on leave ~~s. 9(2)(a)~~ ~~333 s. 6(a)~~

³²² Witness 6, 1 November 2017, A5.

³²³ Witness 5, 31 October 2017, Q20.

³²⁴ Exhibit BV, Enclosure 3, p 22-24; Witness 6, 1 November 2017, A5.

³²⁵ Witness 6, 1 November 2017, Q16-17.

³²⁶ Witness 3, 31 October 2017, Q9; Witness 7, 1 November 2017, Q16.

³²⁷ Witness 1, 30 October 2017, Q90-91.

³²⁸ See para 34.

~~s. 6(a)~~

³³⁰ ~~s. 6(a)~~ and SGT Taylor.

³³¹ ~~s. 6(a)~~

³³² Witness 20, 21 November 2017, Q81-84; Witness 2, 30 October 2017, Q85-89; Witness 1, 30 October 2017, Q95-101; Witness 3, 31 October 2017, Q9-12; Witness 7, 1 November 2017, Q16-19.

³³³ Witness 5, 31 October 2017, Q16; Witness 1, 30 October 2017, Q91-93.

³³⁴ Witness 5, 31 October 2017, Q15; Witness 3, 31 October 2017, Q12; Witness 1, 30 October 2017, Q96; Witness 2, 30 October 2017, Q86-89.

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s. 6(a)

- ~~OPENED~~ ~~RELEASED~~ ~~MAILED~~ ~~REF ID: A11744~~
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- ³³⁵ Witness 31, 22 November 2017, Q3.
- ³³⁶ Witness 6, 1 November 2017, Q14.
- ³³⁷ Witness 5, 31 October 2017, Q15; Witness 3, 31 October 2017, Q12; Witness 1, 30 October 2017, Q96; Witness 2, 30 October 2017, Q86-89.
- ³³⁸ Witness 5, 31 October 2017, Q15; Witness 1, 30 October 2017, Q99.
- ³³⁹ Witness 31, 22 November 2017, Q3.
- ³⁴⁰ Witness 13, 31 October 2017, Q21; Witness 2, 30 October 2017, Q13; Witness 3, 31 October 2017, Q12.
- ³⁴¹ Witness 6, 1 November 2017, Q14.
- ³⁴² Witness 31, 22 November 2017, Q3; Witness 5, 31 October 2017, Q23.
- ³⁴³ Witness 5, 31 October 2017, Q23.
- ³⁴⁴ Witness 6, 31 October 2017, Q12.
- ³⁴⁵ Witness 5, 31 October 2017, Q23.
- ³⁴⁶ Ibid, Q53.
- ³⁴⁷ Witness 3, 31 October 2017, Q15.
- ³⁴⁸ Witness 2, 30 October 2017, Q13.
- ³⁴⁹ Witness 3, 31 October 2017, Q15.
- ³⁵⁰ Witness 1, 30 October 2017, Q35; Witness 11, 1 November 2017, Q24-34.
- ³⁵¹ Witness 3, 31 October 2017, Q53.
- ³⁵² Witness 5, 31 October 2017, Q54.
- ³⁵³ Ibid, Q55.

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s. 6(a)

124. (U) Personnel had access to hydration and nutrition throughout the preparation phase with 2 main meals scheduled at 1200 and 1800. Pay as You Dine (PAYD) records indicate that SGT Taylor had lunch at 1214,³⁵⁶ dinner was provided at 1800 but as it was a duty meal there are no PAYD records³⁵⁷. Once deployed from Papakura individuals were responsible for their own nutrition and hydration, which is normal for any operation of short duration³⁵⁸.

125. The Court finds that SGT Taylor had adequate opportunity to remain properly fed and hydrated ahead of the accident and that, for a soldier of his experience, lack of food or hydration is unlikely to have been a significant factor in the accident.

s. 9(2)(a)

³⁵⁴ Ibid, Q56.

³⁵⁵ Exhibit A1, p 4.

³⁵⁶ Exhibit D

³⁵⁷ Witness 1, 4 May 2018, Q 2

³⁵⁸ Witness 1, 4 May 2018, Q 2-4

³⁵⁹ Exhibit CR p 17-18; Tests conducted for a range of antipsychotics, narcotics, antidepressants, antihistamines, sedatives and drugs of abuse.

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s. 9(2)(a)

127. The Court finds that other than caffeine there were no drugs or alcohol present in SGT Taylor's system at the time of the accident.
s. 6(a)

³⁶⁴ Conditions during the transit were described by s. 6(a) as manageable³⁶⁵ and by s. 6(a) as nothing out of the ordinary³⁶⁶ allowing for a s. 6(a) transit for the majority of the passage.³⁶⁷ There was some variation with rougher conditions experienced during the transit of the Colville Channel.³⁶⁸

129. (U) The RHIBs remained in the waiting area until approximately 0500,³⁶⁹ during which time personnel were able to get some limited rest, although conditions were such that an element of fatigue was inevitable.³⁷⁰ s. 6(a) gave evidence that SGT Taylor remained awake throughout this period, and s. 6(a) gave evidence that SGT Taylor was in good spirits.³⁷¹ During the transit, communications were maintained with the team on board MV Olivia Maersk in order to monitor her progress from Tauranga.³⁷² Some minor re-planning was conducted during the wait due to the delayed arrival of the target vessel and the desire to complete the activity before 0700.³⁷³
s. 6(a)

³⁶⁰ Witness 43, 14 December 2018, Q5, Q19-22

³⁶¹ Ibid Q22

³⁶² Witness 5, 31 October 2017, Q56.

³⁶³ Exhibit A1, p 3; Witness 11, 2 November 2017, Q37.

³⁶⁴ Exhibit A1, p 4.

³⁶⁵ Witness 6, 1 November 2017, Q15.

³⁶⁶ Witness 19, 3 November 2017, Q22; Witness 18, 3 November 2017, Q19.

³⁶⁷ Witness 5, 31 October 2017, Q57; Witness 13, 2 November 2017, Q59.

³⁶⁸ Witness 18, 3 November 2017, Q14-21.

³⁶⁹ Witness 5, 31 October 2017, Q65; Witness 1, 30 October 2017, Q46; Exhibit A1 p 4.

³⁷⁰ Witness 2, 30 October 2017, Q26-31; Witness 5, 31 October 2017, Q63-65; Witness 6, 1 November 2017, Q16-17; Witness 22, 21 November 2017, Q17-18.

³⁷¹ Witness 16, 3 November 2017, Q35; Witness 18, 3 November 2017, Q27.

³⁷² Witness 13, 31 October 2017, Q50.

³⁷³ Witness 5, 31 October 2017, Q64; Witness 1, 30 October 2017, Q50.

³⁷⁴ Witness 1, 30 October 2017, Q51; Exhibit A1, p 4.

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s. 6(a)

with the boats arriving in a position to commence the assault at 0550.³⁷⁵

131. (U) During the final run in to the assault, the coxswain in RHIB was receiving updates from SGT Taylor. He commented on SGT Taylor's elevated energy and enthusiasm for the task at hand.³⁷⁶

Planning and Risk Management

132. (U) The Court finds that the planners carried out appropriate risk management steps for the activity in accordance with established procedures.

133. (U) The Court further finds that whilst these procedures were sufficiently robust, improvements can be made in the area of monitoring individual levels of currency for underway tagging.

s. 6(a)

The plan was initially to have involved HMNZS OTAGO in support³⁷⁸ but, due to the delayed departure of the target vessel and scheduling constraints on OTAGO, this aspect of the exercise was cancelled.³⁷⁹ The Court finds this had no significant effect on the events surrounding the accident.³⁸⁰

s. 6(a)

136. ~~(P)~~ A similar activity had been conducted in March 2017, s. 6(a) that had also focussed on MCT training.³⁸³ Command elements of D Squadron and 1 NZSAS Regiment considered s. 6(a) to be a follow-on activity.³⁸⁴ Although some personnel within the Squadron were new, it was considered there were no significant increases in the drivers of risk.³⁸⁵ CO 1 NZSAS Regiment was briefed on the activity during the

³⁷⁵ Witness 5, 31 October 2017, Q66.

³⁷⁶ Witness 13, 2 November 2017, Q132.

³⁷⁷ Witness 46, 25 January 2018, Q7; Witness 1, 30 October 2017, Q12; Witness 5, 31 October 2017, Q39; Exhibit B, p 15.

³⁷⁸ Witness 5, 31 October 2017, Q9-11.

³⁷⁹ Witness 1, 30 October 2017, Q21.

³⁸⁰ Witness 5, 31 October 2017, Q40-41.

³⁸¹ Witness 5, 31 October 2017, Q12.

³⁸² Witness 1, 30 October 2017, Q1 and 2; Witness 5, 31 October 2017, Q1 and 2. Planning Staff were s. 6(a) and SGT Taylor.

³⁸³ Witness 1, 30 October 2017, Q12; Witness 46, 25 January 2018, Q7; Exhibit BV, Enclosure 10.

³⁸⁴ Witness 1, 30 October 2017, Q12; Witness 46, 25 January 2018, Q7.

³⁸⁵ Witness 46, 25 January 2018, Q7-8.

planning phase, provided guidance and was content with the preparations.³⁸⁶

137. (U) Collective training to achieve OLOC for Counter Terrorism Response is accepted by the Chief of Defence Force to be an operational activity under section 7(5) of the Health and Safety at Work Act.³⁸⁷ The risk appetite for this type of activity reflects the fact that realistic field training in the context of Special Forces is inherently dangerous but that it must not come at the expense of safety and must be conducted under controlled conditions.³⁸⁸

138. (U) The risk management policy within 1 NZSAS Regiment had been subject to a continuous improvement review in order to develop tools that would improve risk assessment³⁸⁹ and, although the set of tools for MCT had not been fully developed at the time of the accident,³⁹⁰ guidance was available from NZDF, Army and Unit policy.³⁹¹ ~~s. 6(a)~~ utilised the risk assessment matrix developed for the MCT Techniques Course³⁹² as a check list for hazard identification and mitigation strategies.³⁹³ This matrix contains sections covering all aspects of the activities undertaken for ~~s. 6(a)~~³⁹⁶

The Court finds that the assessment of risk was a fundamental part of the training planning process³⁹⁷ and the procedures followed led to the development of a comprehensive safety plan, of which the main output was the safety brief.³⁹⁸

139. (U) The Court recommends that 1 NZSAS Regiment continue to develop the tools available for risk assessment as a priority and bring them fully into use as soon as practicable. A review of the hazards, hazard scores and mitigation strategies associated with MCT should be conducted in light of this report. As part of the planning process individually tailored matrices should be generated each time activities of the scale of ~~s. 6(a)~~ are conducted.

140. (U) The planning process included contact with the target vessel MV Olivia Maersk, initially via e-mail to establish the parameters of the

³⁸⁶ Ibid, Q11.

³⁸⁷ Exhibit DH, Enclosure 2.

³⁸⁸ Exhibit S, para 1.1.16.

³⁸⁹ Witness 46, 25 January 2017, Q9.

³⁹⁰ Witness 1, 30 October 2017, Q87.

³⁹¹ Exhibit CW; Exhibit CX; Exhibit S, para 1.1.17.

³⁹² Exhibit DY

³⁹³ Witness 1, 4 May 2018, Q11

³⁹⁴ Ibid p 3-4

³⁹⁵ Ibid p 6

³⁹⁶ Ibid p 6-7

³⁹⁷ Exhibit S, para 1.1.16.

³⁹⁸ Witness 2, 30 October 2017, Q12-15, see para 151.f.

exercise³⁹⁹ and then a face to face briefing and reconnoitre of the ship immediately prior to the exercise.⁴⁰⁰ **s. 6(a)**

- ⁴⁰² It also covered the emergency procedures in the event of a casualty and no go areas on the ship.⁴⁰³
141. (U) Following the briefing, **s. 6(a)** accompanied the ship's Chief Engineer to reconnoitre the vessel in detail.⁴⁰⁴ This included examination of potential tagging points which included guardrails the use of which raised no concerns at the time.⁴⁰⁵ The operators forming the enemy party who were to embark in the MV Olivia Maersk received a ship safety brief and orientation tour on arrival on board.⁴⁰⁶
142. (U) The overarching safety plan for the exercise was developed by **s. 6(a)** with input from **s. 6(a)** following the reconnaissance of the MV Olivia Maersk.⁴⁰⁷ The plan was produced in accordance with guidance from 1 NZSAS Regiment Standing Orders **s. 6(a)**
- ⁴⁰⁸ Independent weather planning was also conducted by and briefed to the RHIB crews and command element.⁴⁰⁹ The Court finds that whilst there is no dedicated meteorological support to D Squadron, expertise within the unit is currently sufficient.⁴¹⁰
143. (U) The Court recommends that D Squadron explore the formal provision of meteorological support to ensure effective forecasting is available at all times.
144. (U) 1 NZSAS Regiment Standing Orders **s. 6(a)** calls for a medical plan approved by the Regimental Medical Officer (RMO) and Officer Commanding the activity to be produced for all training.⁴¹¹ The medical plan was generated by **s. 6(a)** on return from the visit to MV Olivia Maersk, and, although it was discussed with **s. 6(a)** (the medic assigned for the exercise), it was not passed through the RMO.⁴¹² The plan as briefed

³⁹⁹ Exhibit A; Witness 45, 21 December 2017, Q17.

⁴⁰⁰ Witness 1, 30 October 2017, Q21; Witness 2, 30 October 2017, Q13.

⁴⁰¹ Witness 1, 30 October 2017, Q21; Witness 2, 30 October 2017, Q13.

⁴⁰² Witness 1, 30 October 2017, Q21; Witness 2, 30 October 2017, Q13; Witness 45, 21 December 2017, Q17.

⁴⁰³ Witness 2, 30 October 2017, Q13; Witness 1, 30 October 2017, Q21; Witness 45, 21 December 2017, Q17.

⁴⁰⁴ Witness 3, 31 October 2017, Q13; Witness 45, 21 December 2017, Q18.

⁴⁰⁵ Witness 1, 4 May 2018, Q 8-9.

⁴⁰⁶ Witness 45, 21 December 2017, Q19; Witness 29, 22 November 2017, Q6-8.

⁴⁰⁷ Witness 2, 30 October 2017, Q15-18; Witness 1, October 30 2017, Q22:

⁴⁰⁸ Witness 2, 30 October 2017, Q15; Exhibit F; Exhibit S, Ch 2; Exhibit U, Annex C.

⁴⁰⁹ Witness 1, 30 October 2017, Q35; Witness 11, 2 November 2017, Q8; Exhibit AJ, p 5.

⁴¹⁰ Witness 5, 31 October 2017, Q30.

⁴¹¹ Exhibit S, para 1.2.08.

⁴¹² Witness 2, 14 December 2017, Q8-13.

contained the main elements required by standing orders.⁴¹³ Contact details of local medical facilities was not explicitly briefed⁴¹⁴, however, given the offshore location of the activity and that all evacuation plans would be executed through emergency services,⁴¹⁵ the Court does not consider this to be a significant shortcoming.

145. (U) The Court recommends that planning staff are reminded of the necessity to pass medical plans through the RMO.
146. (U) During the briefing process, contingency plans were discussed in detail including actions to be undertaken following RHIB malfunctions,⁴¹⁶ man over board reactions⁴¹⁷ and casualty reactions.⁴¹⁸
147. (U) During the planning of training exercises, 1 NZSAS Regiment Standing Orders ~~s. 6(a)~~ requires that "Training is to be progressive to ensure that participants can build on previously learned skills."⁴¹⁹ The Court found that the level of experience and currency in underway offshore tagging varied widely amongst the participants⁴²⁰ with some undertaking this activity for the first time.⁴²¹ There is currently no mechanism for planning staff to monitor the experience and currency of participants,⁴²² and planning staff were unaware that some members of the team had not previously conducted underway tags.⁴²³ There was a degree of assumption that all personnel who had completed ~~s. 6(a)~~ or equivalent historic training would have completed sufficient training to conduct underway tags.⁴²⁴
148. (U) The Court finds that despite the variation in experience of underway tagging personnel were adequately prepared for the activity. However, the lack of awareness of individual currency by planning staff meant associated risks were not able to be identified. This could have had a more significant impact had environmental conditions been more marginal or if the activity had occurred during darkness as originally planned.
149. (U) The Court recommends that a process be developed by D Squadron to allow planning staff to monitor currency and shortfalls in experience for personnel with regard to underway tagging.

⁴¹³ Exhibit B, p 32; Exhibit F; Exhibit S, para 1.2.06-1.2.08.

⁴¹⁴ Exhibit B, p 32; Exhibit F.

⁴¹⁵ Witness 5, 31 October 2017, Q50.

⁴¹⁶ Witness 5, 31 October 2017, Q44.

⁴¹⁷ Ibid.

⁴¹⁸ Ibid Q50.

⁴¹⁹ Exhibit S, para 1.2.03.f.

⁴²⁰ See paras 87-93 for discussion.

⁴²¹ Ibid.

⁴²² Witness 35, 14 December 2017, Q19 and 22; Witness 2, 14 December 2017, Q5.

⁴²³ Witness 1, 14 December 2017, Q2; Witness 2, 12 December 2017, Q2; Witness 6, 1 November 2017, Q6.

⁴²⁴ Witness 1, 14 December 2017, Q2.

Briefings

150. (U) The Court finds that the briefing process was in accordance with standing orders and conducted comprehensively. Further, the Court finds that the briefing of detailed contingency plans contributed to the rapid and effective response by personnel when the accident occurred.
151. (U) As a no-notice exercise, briefing of personnel involved in the exercise was conducted on 12 October once the operators had been activated by pager to report for duty.⁴²⁵ Briefings fell into seven categories:
- a. Initial Group Briefing. This was conducted by ~~s. 6(a)~~ and was directed at all operators taking part in the assault, informing them of the general nature of the task and equipment requirements.⁴²⁶
 - b. Formal Orders. Orders were issued verbally with PowerPoint slides⁴²⁷ between ~~s. 6(a)~~ at a comprehensive briefing conducted by ~~s. 6(a)~~. This brief covered all information required by operators to conduct group, sub-team and personal planning.⁴²⁸ ~~s. 6(a)~~ the group commanders, considered the briefings thorough and well planned.⁴²⁹
 - c. Group Orders. Group Commanders provided verbal briefs to the ~~s. 6(a)~~ assault groups.⁴³⁰
 - d. Rehearsal of Concept Drill. This was conducted between ~~s. 6(a)~~ and involved walking through the scheme of manoeuvre on a floor plan showing key geographic features followed by stepping through each phase of the activity and contingency plans. This included drills to follow in the event of failed tags, man overboard action at different phases of the scheme of manoeuvre and the relative movement of the various RHIBs in these situations.⁴³¹
 - e. RHIB Brief. Following the Rehearsal of Concept Drill, ~~s. 6(a)~~ back-briefed ~~s. 6(a)~~ and SGT Taylor on the detailed RHIB planning.⁴³² Given ~~s. 6(a)~~ position as acting commander of the RHIB Detachment, ~~s. 6(a)~~ wanted to ensure planning was sound.⁴³³ Following this back brief, the RHIB detachment held its own detailed briefing.⁴³⁴

⁴²⁵ Witness 5, 31 October 2017, Q23.

⁴²⁶ Ibid.

⁴²⁷ Exhibit B, p 1-42.

⁴²⁸ Witness 5, 31 October 2017, Q23-53.

⁴²⁹ Witness 6, 31 October 2017, Q13; Witness 21, 21 November 2017, Q12.

⁴³⁰ Witness 5, 31 October 2017, Q53.

⁴³¹ Witness 1, 30 October 2017, Q30-34; Witness 5, 31 October 2017, Q53.

⁴³² Witness 11, 2 November 2017, Q23.

⁴³³ Witness 1, 30 October 2017, Q35.

⁴³⁴ Witness 11, 2 November 2017, Q24-34.

- f. Safety Brief. ^{s. 6(a)} delivered a final safety brief between ^{s. 6(a)} 435 this was in accordance with guidance in 1 NZSAS Regiment Standing Orders ^{s. 6(a)} ⁴³⁶ The plan was briefed to all participants⁴³⁷ and, whilst the weather portion of the brief does not appear on exhibit F, that element had been incorporated into the formal orders by ^{s. 6(a)}³⁸ and was covered during the brief.⁴³⁹ At the brief, it was confirmed with all personnel that they were confident in their capability to conduct the planned activity.⁴⁴⁰
- g. Briefing to Personnel in MV Olivia Maersk. The enemy party and safety numbers in the MV Olivia Maersk were briefed on the overall plan on their arrival in Tauranga prior to boarding the MV Olivia Maersk,⁴⁴¹ they then received a safety briefs once on board, from the ship's Master and Chief Officer covering actions in the event of an emergency in the ship;⁴⁴² further briefs on the conduct of the exercise and safety were delivered by ^{s. 6(a)} and ^{s. 6(a)}

SGT Taylor's Equipment

152. ~~(P)~~ The Court finds that SGT Taylor was wearing standard assault equipment with some minor personal additions:⁴⁴⁴
- a. Bump Helmet serial No 07616010;
 - b. ^{s. 6(a)}
 - c. Helmet mounted strobe light;
 - d. FRIS Suit;⁴⁴⁵
 - e. Boots;
 - f. Body Armour ^{s. 6(a)}
 - g. Weapon Sling;
 - h. HK MP5 ^{s. 6(a)} Machine Gun) Configured for SIMFIRE;
 - i. Pistol belt and holster;
 - j. Glock SIMFIRE Pistol;
 - k. ^{s. 6(a)}-HK MP5 Magazine with SIMFIRE ammunition;
 - l. ^{s. 6(a)} 5.56 Magazine with ^{s. 6(a)} SIMFIRE ammunition;

⁴³⁵ Witness 1, 30 October 2017, Q36; Witness 5, 31 October 2017, Q53.

⁴³⁶ Exhibit 5, Ch 2 Annex B; Exhibit F.

⁴³⁷ Witness 5, 31 October 2017, Q29.

⁴³⁸ Witness 5, 31 October 2017, Q29-35; Exhibit B, p 5-6.

⁴³⁹ Witness 1, 30 October 2017, Q36.

⁴⁴⁰ Witness 2, 14 December 2017, Q4.

⁴⁴¹ Witness 30, 22 November 2017, Q4.

⁴⁴² Witness 30, 22 November 2017, Q4; Witness 31, 22 November 2017, Q4; Witness 45, 21 December 2017, Q19.

⁴⁴³ Witness 30, 22 November 2017, Q4; Witness 29, 22 November 2017, Q3.

⁴⁴⁴ Exhibit Q, p 45-67, p 87 and p 97-109; Exhibit CJ, p 1.

⁴⁴⁵ Witness 1, 30 October 2017, Q68.

- m. Knife & Marine Flare;
- n. 5 Cyalume chemical lights⁴⁴⁶;
- o. ISP Mk 3 363N Special Forces Life Jacket Serial No 1482018;
- p. Webbing;
- q. ~~s. 6(a)~~ Radio & headset;
- r. Strike Face Mask;
- s. ~~s. 6(a)~~ and
- t. Watch.

153. (U) Fig 10 is representative of the configuration SGT Taylor was wearing.
~~s. 6(a)~~ checked SGT Taylor's equipment configuration immediately ahead of the exercise; there were no anomalies noted.⁴⁴⁷
154. (U) The Court finds that SGT Taylor's equipment was configured in a standard fashion that was well-established and trusted by the operators;⁴⁴⁸ all the assault equipment he was using had been introduced into service.⁴⁴⁹

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⁴⁴⁶ Four were in his webbing. One was in the sleeve of FRIS suit.

⁴⁴⁷ Witness 5, 31 October 2017, Q55-56; Witness 2, 30 October 2017, Q91.

⁴⁴⁸ Witness 6, 31 October 2017, Q97-98.

⁴⁴⁹ Witness 1, 30 October 2017, Q112.

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(R) Fig 10 Representative Configuration of Equipment worn by SGT Taylor⁴⁵⁰

⁴⁵⁰ Exhibit Q, p 84.

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Additional Equipment

155. (U) The Court finds on the balance of probabilities that the ladder and ancillary equipment used in the climb were in date in terms of their testing requirements and that specifications are appropriate for use in underway tagging operations. However, test certificates for ladders rate them at s. 6(a) and given that they are routinely used with s. 6(a)

on the ladder the Court finds that the total dynamic load on the ladders during tagging operations is likely to exceed this value. Further there is no documentation to support the rating for the s. 6(a) used in conjunction with the ladders.

156. (U) The Court recommends that 1 NZSAS Regiment ensure all s. 6(a) ladders are recertified and that specifications of associated ancillary equipment is confirmed to account for the actual loads to which they are likely to be subjected. Further, until this occurs The Court recommends the use of the ladders and ancillary equipment for underway tagging be limited to activities directly linked to the generation and maintenance of OLOC.

s. 6(a)

158. (U) Whilst test certification only indicates a rating of s. 6(a) 453 manufacturers specifications for the ladders rate the breaking load of the s. 6(a) 454 and failure of the rungs as greater than s. 6(a) 454

The Court finds that the specification of the ladders is appropriate for their use in underway tagging operations, however, they are not currently certified to this level..

159. (U) The weight of personnel using the ladder will be highly variable, however, a DTA report examining suitability of life jackets⁴⁵⁵ used a sample of 3 personnel from D Squadron with an average weight of 85.2kg with a standard deviation of 7.3kg and equipment weighing 28.5kg with a standard deviation of 0.6kg⁴⁵⁶. This gives an indicative total weight of 113.7kg with a standard deviation of 7.9kg. A second DTA report⁴⁵⁷

⁴⁵¹ Exhibit CJ p 27-28

⁴⁵² Exhibit DR

⁴⁵³ Exhibit CJ p26-27, Exhibit DR

⁴⁵⁴ Exhibit DT

⁴⁵⁵ Exhibit DC para 7-9

⁴⁵⁶ Ibid

⁴⁵⁷ Exhibit DX

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comparing the SFLJ in water performance with that of the First Spear Aegir 59 integrated body armour and PFD used a sample size of 8 personnel with a mean fully equipped weight of 120.8 kgs with the heaviest individual weighing 140.5kgs⁴⁵⁸. Using these figures the Court finds that s. 6(a)

Further the

Court finds that noting the acceleration personnel will be subjected to in underway tagging operations, due to heave and roll of the target ship, it is also possible that a single climber on the ladder may exceed the s. 6(a) rating when dynamic loading is taken into account.

160. Ancillary load bearing equipment connected to the ladder for tagging operations consists of s. 6(a)

⁴⁶⁰ s. 6(a)

although recommended by

the ladder manufacturer do not currently have documentation available within the specialist store at Papakura Camp that details their load rating.⁴⁶¹ These ancillary items have no life of type⁴⁶² and fall under the inspection regime for mountaineering equipment detailed in NZ P97 8465.01⁴⁶³, this equipment is visually inspected prior to issue from the specialist store and prior to use by the operators.⁴⁶⁴

161. (U) There was an accounting discrepancy with respect to the s. 6(a) ladders in use. s. 6(a) ladders are registered and these had been inspected by Cookes in two batches, December 2016 and February 2017.⁴⁶⁵ Invoices for both inspections were available,⁴⁶⁶ but only 1 inspection certificate for a s. 6(a) ladder from the February batch was available for inspection.⁴⁶⁷

162. (U) The ladder used in s. 6(a) was from the February batch.⁴⁶⁸ Further, the ladder used in the climb had had the metal serial number tag removed, making a direct comparison with any records impossible.⁴⁶⁹

163. (U) The Court recommends that all safety equipment requiring testing is labelled sufficiently to ensure accurate comparison with test certification.

⁴⁵⁸ Exhibit DX

⁴⁵⁹ Exhibit DU

⁴⁶⁰ Witness 40, 4 May 2018, Q27-29

⁴⁶¹ Witness 50, 4 May 2018, Q5; Witness 40, 4 May 2018, Q24

⁴⁶² Exhibit DZ Section 1 Ch 1 para 8

⁴⁶³ Witness 40, 4 May 2018, Q19-25; Exhibit DZ Section 2 Ch 2

⁴⁶⁴ Witness 40, 4 May 2018, Q 31; Exhibit DZ

⁴⁶⁵ Witness 40, 24 November 2017, Q14; Exhibit CJ, p 24-28.

⁴⁶⁶ Exhibit CJ, p 28.

⁴⁶⁷ Exhibit CJ p26-27; Exhibit DR, Witness 40, 24 November 2017, Q14

⁴⁶⁸ Ibid, Q19.

⁴⁶⁹ Ibid, Q22.

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Role of the Equipment in the Accident

164. (U) The Court finds that the main causal factor in SGT Taylor's fall was the hazard present due to the use of a ~~s. 6(a)~~ ladder. The Court accepts that this technique represents best practice; it has been in use for some time, is widely used by other defence and security forces worldwide⁴⁷⁰ and allows for effective tagging.
165. (U) Whilst the hazards are known and mitigated by training, the Court recommends that Force Development Wing and D Squadron maintain contact with partner organisations utilising this technique in order to remain abreast of innovations that may further mitigate these hazards.
166. (U) The Court considered the evidence on the use of guardrails as an attachment point during tagging operations. ~~s. 6(a)~~
167. (U) The Court finds that the failure of the guardrail during ~~s. 6(a)~~ was not a direct causal factor in the accident but that it may have contributed to the difficulty of the climb after it failed. The Court does however identify the use of the guardrail for tagging as a safety issue as the consequences of its failure could have been more severe. The use of guardrails for tagging introduces an additional hazard of their failure under the weight of climbers. The Court recommends that D Squadron highlight the risk of failure associated with the use of guardrails for tagging within the overall risk assessment of the activity but accepts that for operational reasons their use is often necessary.
~~s. 6(a)~~

⁴⁷⁰ Witness 50, 4 May 2018, Q35-38

⁴⁷¹ Exhibit DV

⁴⁷² Witness 1 4 May 2018 Q 10

⁴⁷³ Witness 42 14 December 2017 Q35-36

⁴⁷⁴ Witness 6, 1 November 2017, Q89-91; Exhibit Q, p 39 Photo 54.

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s. 6(a)

⁴⁷⁵ The Court finds that these minor modifications had no bearing on the occurrence or outcome of the accident.

169. (U) A number of witnesses identified the snagging hazards that are present due to the nature of equipment worn and carried by assaulters.⁴⁷⁶ These hazards which include the increased standoff from the ladder are well understood and the interaction between the ladders used and equipment is fully appreciated by assaulters.⁴⁷⁷ The increased standoff from the ladder is in part a result of the bulk of the SFLJ and the effect is to increase loading on the arms⁴⁷⁸, climbing techniques are utilised that mitigate the impact as much as possible⁴⁷⁹. The Court finds that these snagging hazards are sufficiently mitigated by training and procedures. The Court notes the anecdotal evidence of reduced snagging hazards that the trial of the First Spear Armour System⁴⁸⁰ has identified. The Court recommends that Force Development Wing and D Squadron expedites the completion of the trial to identify if this equipment is a potential alternative to the SFLJ.

170. (R) The Court examined evidence of systems to mitigate against fatigue when climbing during tagging operations. s. 6(a)

⁴⁸¹ However, for shorter climbs such as the one to the MV Olivia Maersk, it is not generally used unless climbers lacked confidence or experience⁴⁸². SGT Taylor had used this system previously in his career.⁴⁸³ Witness 50, who had seen SGT Taylor climb many times,⁴⁸⁴ felt it was unlikely that SGT Taylor would have considered using this arrangement on 13 October⁴⁸⁵. This technique was not specifically considered as a mitigation strategy during the planning of the operation.⁴⁸⁶ The equipment to allow this technique to be used had not been formally introduced into service at the time of the accident but was raised with

⁴⁷⁵ Witness 40, 4 May 2018, Q 31-33

⁴⁷⁶ Witness 6, 1 November 2017, Q98-99; Witness 50 4 May 2018, Q53

⁴⁷⁷ Witness 6, 1 November 2017, Q98-99; Witness 50, 4 May 2018, Q 26 &53

⁴⁷⁸ Witness 40, 4 May 2018, Q26

⁴⁷⁹ ibid

⁴⁸⁰ Witness 6, 1 November 2017, Q99-102; Witness 50, 4 May 2018, Q29-30 &Q55-56

⁴⁸¹ Witness 50, 4 May 2018, Q 14-19

⁴⁸² Ibid Q22-23

⁴⁸³ Witness 50, 4 May 2018 Q15 and 22

⁴⁸⁴ Ibid Q44-45

⁴⁸⁵ Ibid Q22

⁴⁸⁶ Witness 2, 31 October 2017, Q92.

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Force Development Wing in May 2018.⁴⁸⁷ The Court recommends that 1 NZSAS Regiment and Force Development Wing introduce ^{s. 6(a)} or similar system into service and add it to the risk matrix for activities using a ^{s. 6(a)} ladder as a potential treatment to the hazard of falls.

171. (U) ^{s. 6(a)} worn by SGT Taylor⁴⁸⁸ is issued to divers but not all members of D Squadron.⁴⁸⁹ Whilst not a standard part of the equipment, it was not unusual that it was worn and would not have had an impact on the accident.⁴⁹⁰

Safety Equipment

172. (U) The Court finds that all safety equipment used by personnel during this activity functioned as expected.

173. (U) Safety equipment used by personnel was drawn from 1 NZSAS Regiment specialist stores at Papakura Military Camp.⁴⁹¹ An inspection of certification for safety equipment confirmed that all lifejackets in use on the day were in date for inspection.⁴⁹² SGT Taylor signed out SFLJ 1300470;⁴⁹³ however, he in fact wore SFLJ 1482018,⁴⁹⁴ which had been signed out from the stores as part of the ^{s. 6(a)} 95

Further Safety Equipment Comments

174. (U) The Court finds that:

- The Special Forces Lifejacket remains fit for purpose in the Maritime Counter Terrorism role; and
- Whilst there remain risks associated with its use, these are within an acceptable limit given the overall nature of the task.

175. (U) Two types of life jacket are available for use during MCT activities:

- The standard model is the International Safety Products Mk 3 363N Special Forces Life Jacket (SFLJ).⁴⁹⁶
- The second type is the First Spear Armour System, which integrates a personal flotation device (PFD) with combat body armour.⁴⁹⁷

⁴⁸⁷ Witness 50, 4 May 2018, Q 20

⁴⁸⁸ Para 152.s.

⁴⁸⁹ Witness 1, 30 October 2017, Q68.

⁴⁹⁰ Ibid.

⁴⁹¹ Witness 40, 24 November 2017, Q4-5.

⁴⁹² Exhibit CJ.

⁴⁹³ Ibid p 3.

⁴⁹⁴ Witness 40, 24 November 2017, Q4-8.

⁴⁹⁵ Exhibit CJ, p 6; Witness 40, 24 November 2017, Q4.

⁴⁹⁶ Exhibit DK.

⁴⁹⁷ Witness 1, 30 October 2017, Q113 and Q115; Witness 6, 31 October 2017, Q100-101.

176. (U) The First Spear Armour System whilst not yet introduced into service is approved by SOTC for use by MCT swimmers and RHIB detachment personnel during MCT activities and training.⁴⁹⁸ The First Spear system has the advantage of being less cumbersome and allowing better movement whilst climbing.⁴⁹⁹ Both of these systems require manual activation of the PFD.⁵⁰⁰
177. (R) A report was produced by the Defence Technology Agency (DTA) in 2014 to provide a rapid assessment of the SFLJ.⁵⁰¹ This test was conducted on three individuals in a number of equipment configurations, one of which bore a close similarity to that worn by SGT Taylor on 13 October 2017.⁵⁰² Whilst acknowledging that the sample size of personnel used in the test was below the recommended number⁵⁰³ and that the freeboard⁵⁰⁴ measured in some circumstances did not meet with the international standard being used,⁵⁰⁵ the report concluded, "Taken as a whole, the results provide indicative evidence that the ISP 363N SF (MK3) PFD remains fit for its current purpose (i.e. Marine Counter Terrorism and Strategic Reconnaissance Small Boat operations where the User will be recovered rapidly)."⁵⁰⁶
178. (U) Two expert witnesses were consulted about the report and the continued fitness of the SFLJ for use in light of the accident on 13 October 2017. Witness 47 is a naval officer who was heavily involved in the development of the NZDF's Operational Personal Flotation Device (OPFD)⁵⁰⁷ and Witness 48 is a DTA scientist who has been involved in the testing and evaluation of PFDs.⁵⁰⁸
179. (U) Witness 47, was concerned that the compromises that had to be made when wearing the SFLJ in terms of its overall impact on operators' ability to carry out their roles called its suitability into question.⁵⁰⁹ In particular, he raised concerns about the lack of an automatic activation system which would result in the life jacket not being effective for an unconscious person.⁵¹⁰ He suggested that consideration should be given

⁴⁹⁸ Exhibit BW.

⁴⁹⁹ Witness 6, 31 October 2017, Q102.

⁵⁰⁰ Witness 1, 30 October 2017, Q67.

⁵⁰¹ Exhibit DC.

⁵⁰² Witness 48, 15 February 2018, Q10.

⁵⁰³ Exhibit DC, para 32.

⁵⁰⁴ Freeboard is the clearance between the mouth and the water when the PFD is inflated.

⁵⁰⁵ Exhibit DC, para 26; Witness 48, 15 February 2018, Q11.

⁵⁰⁶ Exhibit DC, para 24.

⁵⁰⁷ Witness 47, 15 February 2018, Q2-4.

⁵⁰⁸ Witness 48, 15 February 2018, Q2-6.

⁵⁰⁹ Witness 47, 15 February 2018, Q10.

⁵¹⁰ Ibid, Q11.

[REDACTED]
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to developing an automatic activation system⁵¹¹ and gave an example of one such system currently available.⁵¹² He acknowledged that there would be times during operations that automatically activated inflation would not be desirable.⁵¹³

180. (U) Witness 48 who had been involved in the production of the DTA report into the SFLJ supported the conclusion that it remained fit for purpose within the limitations detailed in the report.⁵¹⁴ Whilst he acknowledged some compromises had to be made when wearing the SFLJ in order to allow users sufficient freedom of motion to conduct their roles,⁵¹⁵ he maintained that there was sufficient buoyancy within the system to compensate for this.⁵¹⁶ He explained that, in some circumstances, the use of automatic activation of the SFLJ was not appropriate in an SF environment.⁵¹⁷
181. (U) Both Witness 47 and 48 acknowledged that the SFLJ is a robust and effective system with a large provision of buoyancy capable of supporting fully equipped personnel when inflated.⁵¹⁸
182. (U) Whilst the provision of an automatically activated PFD may have altered the outcome of this accident, the Court accepts that for tactical reasons in an operational environment it is unlikely that the use of such a mechanism could be sanctioned. Given that the activity on 12-13 October was a test of OLOC, it was reasonable for personnel to be configured as fully as possible for a live operation.
183. (U) The Court recommends that, for training involving underway tagging where a degree of compromise of operational realism can be accepted, in order to enhance safety, the use of an automatically activated PFD should be considered. As such, Force Development Wing should undertake an investigation into the viability for the provision of such a suitable system.
184. (U) The Court further recommends that any decision to utilise automatically activated PFDs should be taken in light of all identifiable hazards associated with the activity and of the second and third order effects of their use.

⁵¹¹Ibid, Q14.

⁵¹²Witness 47, 15 February 2018; Exhibit DE.

⁵¹³Witness 47, 15 February 2018, Q20.

⁵¹⁴Witness 48, 15 February 2018, Q15.

⁵¹⁵Ibid, Q13-14.

⁵¹⁶Ibid, Q14.

⁵¹⁷Ibid, Q16.

⁵¹⁸Witness 47, 15 February 2018, Q10; Witness 48, 15 February 2018, Q12.

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Post-Accident Examination of Equipment

185. (U) After the accident, the SIMFIRE attachments to SGT Taylor's HKMP5 was noted to have been damaged and an armourer's inspection conducted.⁵¹⁹ The damage was found to be consistent with impact to hard surface following a fall from 6-8m.⁵²⁰
186. (U) Life Jackets that required servicing following the exercise were inspected by ^{s. 6(a)} One of these failed the inspection due to a damaged bladder.⁵²¹ This life jacket had previously passed inspection on 2 May 2017.⁵²² The Court found no evidence as to when the damage occurred and concludes this life jacket had no effect on the outcome of the accident.

^{s. 6(a)}

⁵¹⁹ Witness 33, 22 November 2017, Q6-7; Exhibit BR, para 5.

⁵²⁰ Witness 33, 22 November 2017, Q8-9.

⁵²¹ Exhibit CJ, p 19.

⁵²² Exhibit CJ, p 13.

⁵²³ See para 47-48.

⁵²⁴ Witness 12, 2 November 2017, Q68-69.

⁵²⁵ Exhibit CK.

Similar Historical Accidents

190. (U) The Court found no evidence of similar accidents within the Army Safety Reporting System (SRS) between January 2008 and May 2018.⁵²⁶
191. Witness 50 who had been with D Squadron between May 2010 and December 2017 before moving to SOTC as an instructor⁵²⁷ described instances of being snagged and of one occurrence where he almost fell from a ladder but was arrested by the use of s. 6(a)⁵²⁸ arrangement described earlier in the report⁵²⁹. He further reported that there were instances of minor falls particularly during training⁵²⁹ but that he was not aware of any falls similar to SGT Taylor's during his time with D Squadron although there may have been prior to his arrival in 2010⁵³⁰.
192. Witness 51 an NZDF analyst for the Directorate of Safety⁵³¹ executed a search of the SRS database that was refined for 1NZSAS Regiment and focussed on key word searches associated with accidents involving ladders or tagging operations.⁵³² The results did not reveal any similar accidents or incidents involving underway tagging operations or the use of s. 6(a) ladders.⁵³³

Recommendations and Impact on Operations

193. (U) The Court makes the following key recommendations:
- 1 NZSAS Regiment must ensure all s. 6(a) adders are recertified and that specifications of associated ancillary equipment is confirmed to account for the actual loads to which they are likely to be subjected.
 - Further until this occurs the use of the ladders and ancillary equipment for underway tagging should be limited to activities directly linked to the generation and maintenance of OLOC
 - Force Development Wing should undertake an investigation into the viability for the provision of an automatically activated PFD for use in underway tagging training where a degree of compromise of operational realism can be accepted.

⁵²⁶ Witness 51, 15 May 2018, Q 4-8 & Q14-15; Exhibit EA

⁵²⁷ Witness 50, 4 May 2018, Q2

⁵²⁸ Ibid Q12

⁵²⁹ Ibid Q12-13

⁵³⁰ Ibid Q13

⁵³¹ Witness 51, 15 May 2018, Q2

⁵³² Witness 51, 15 May 2018, Q 4-7; Exhibit EA

⁵³³ Witness 51, 15 May 2018, Q 4-8 & Q14-15; Exhibit EA

- d. Further, any decision to utilise automatically activated PFDs should be taken in light of all identifiable hazards associated with the activity and of the second and third order effects of their use.
- e. Force Development Wing and D Squadron should expedite the completion of the trial of the First Spear Armour System as a potential alternative to the SFLJ.
- f. CO 1 NZSAS Regiment should provide guidance on expected currency for personnel conducting underway tagging operations within 1 NZSAS Regiment Standing Orders ^{s. 6(a)}
- g. D Squadron should develop a process to allow planning staff to monitor currency and shortfalls in experience for personnel with regard to underway tagging.
- h. 1 NZSAS Regiment and Force Development Wing should introduce the use of ^{s. 6(a)} or similar system for taking a climbers weight into service.
- i. D Squadron should add the use of ^{s. 6(a)} or similar system for taking a climbers weight to the risk matrix for underway tagging as a potential treatment to the hazard of fatigue leading to falls.

194. (U) The following other recommendations are made:

- a. D Squadron should highlight the risk of failure associated with the use of guardrails for tagging within the overall risk assessment of the activity given that for operational reasons their use is often necessary.
- b. Force Development Wing and D Squadron should maintain contact with partner organisations utilising similar tagging techniques in order to remain abreast of innovations that may further mitigate associated hazards.
- c. D Squadron should explore the formal provision of meteorological support to ensure effective maritime forecasting is available at all times.
- d. ^{s. 6(a)}
- e.
- f. 1 NZSAS Regiment should prioritise the development and publishing of tools to support hazard identification and risk assessment of SOF activities.
- g. D Squadron should review hazards, hazard scores and mitigation strategies for tagging operations in light of this report.
- h. Individually tailored risk matrices should be generated for training activities of the scale of ^{s. 6(a)} as part of the planning process.
- i. D Squadron personnel should be reminded of the importance of raising minor incidents within the safety reporting system.
- j. All planning staff within 1 NZSAS Regiment should be reminded of the necessity to pass medical plans through the RMO.

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- k. Specialist store staff should ensure all safety equipment requiring testing is labelled sufficiently to ensure accurate comparison with test certification.

s. 9(2)(a)

s. 9(2)(a)

s. 9(2)(a)

1NZSAS

Member Court of Inquiry

Date 21/5/18

s. 9(2)(a)

RNZN

President Court of Inquiry

Date 21/5/18

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